A Comparative Evaluation of the Flinders University Rural Clinical School Parallel Rural Community Curriculum and its support programs with the community- based Monash University School of Rural Health East Gippsland and Mildura Rural Schools.

Report prepared by:

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and

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The purpose of undertaking a comparative evaluation of the Flinders University Parallel Rural Community Curriculum (PRCC) and its support programs with the community-based Monash University School of Rural Health East Gippsland and Mildura Rural Schools was to investigate the major relationships that contribute to good outcomes for students, clinicians, health services the community and the government. The evaluation aims were to explore the depth and breadth of student experience and determine any gaps which need to be addressed. Two key questions were developed as the focus of the evaluation, namely:

1. How successful is the program in preparing students for future practice?
2. How does the program address the rural health workforce shortages?

Two external evaluators were engaged to undertake the evaluation. Each brought different areas of expertise to the evaluation process. Associate Professor Hoffie Conradie from the Faculty of Health Science, Stellenbosch University, South Africa brought the perspective of a rural medical educator and doctor. His understanding rural medical education and expertise is evident in his role as the Director of the Ukwanda Centre for Rural Health when he says “The advantage of exposing students to rural life is that they get to experience a diverse range of conditions in which to learn and develop. This provides them with skills well-suited to the development needs of South Africa and other African countries”.

Professor John Halsey is an educator of the highest regard. Professor Halsey brought the perspective of community sustainability and rural education to the evaluation process. Professor Halsey is the former Executive Officer of the Rural Education Forum Australia and the Executive Director in the South Australian Department of Education and Children's Services and Chief of Staff to a State Minister for Education and Children's Services. He is the Sidney Myer Chair of Rural Education and Communities in the Flinders University School of Education.

The evaluation is presented as two separate reports within the one document to capture the perspectives of the two evaluators. Direct quotes are referenced through the use of the letter “F” to indicate it relates to a Flinders University participant and “M” to indicate it relates to a Monash University participant.

This evaluation was approved by Flinders University Social and Behavioural Research Ethics Committee.
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Evaluation data
Evaluation data was collected through a wide range of one-to-one and focus group interviews of approximately an hour’s duration using semi-structured interviews. In most instances interviews were recorded and transcribed verbatim and field notes were taken by the evaluator. The semi-structured interview included questions about the interviewees’ present involvement in the program, questions around their experience of teaching and learning, creating a learning environment, administration, faculty development, research, and community engagement. The interviewees were asked about the perceived benefits of the program, concerns and possible improvements. Lastly, interviewees were asked about the contribution of the program to recruitment and retention of rural health care workers. More than 50 interviews were recorded and transcribed. The qualitative data (open ended questions) of an electronic students survey conducted among 2009 students were also evaluated.

Method of evaluation and report structure
All the transcribed interviews were re-read attempting to highlight emerging themes and supportive quotations. The information was documented on a matrix in columns under the interview questions detailed above and in rows according to the following categories of interviewees; Deans, Directors of Rural Clinical Schools’ (DRCS), Academic Coordinator(AC), General Practitioners (GP’S), specialists, other tutors, administrative personnel, students and community members. From this matrix the reviewer identified the 16 themes that illustrate both the positive aspects of the programs, the differences between the programs at Monash and Flinders and possible areas for improvement.
Theme 1: Relationship between the Medical School, the RCS and the different sites

Theme 2: Sustainability

Theme 3: Selection of students

Theme 4: Students’ experience

Theme 5: GP tutors

Theme 6: Administrative staff

Theme 7: Specialists other than Family Physicians/GP’s

Theme 8: Research

Theme 9: The Parallel Rural Community Curriculum (PRCC)

Theme 10: Community immersion

Theme 11: Inter Professional Education (IPE)

Theme 12: Community engagement

Theme 13: Faculty development

Theme 14: Recruitment and retention

Theme 15: Aboriginal Health

Theme 16: Interuniversity cooperation

**Theme 1: Relationship between the Medical School, the RCS and the different sites**

The structure of the RCS does differ between Monash and Flinders. The main attributes of the two programs will be described in order to highlight the differences.

At Monash there is a School of Rural Health which includes the four RCS’s as well as the University Department of Rural Health (UDRH) at Moe. The four RCS’s i.e. East Gippsland Rural Clinical School (EGRCS), Gippsland RCS, Mildura RCS and Bendigo RCS and their directors seem to function independently, each with their own
distinctive program. From 2010 the Bendigo and the Mildura RCS’s cooperate in the Northern Victoria Rural Medical Education Network (NVRMEN). The directors at EGRCS and Mildura RCS are 0.7 and 0.5 university appointees respectively. The Director at EGRCS is supported by a “faculty” of GP tutors and specialists from the practices involved who meet on a monthly basis. In addition, there is the Gippsland Medical School (GMS) situated in Churchill, a graduate entry medical school. Some third year students from GMS have been allocated to EGRCS in 2010 for the first time. Referring specifically to EGRCS and Mildura RCS, there is no equivalent to the clinical educators as in Flinders and the participating practices usually have one or two GPs who supervise medical students.

The RCS’s at Monash seems to function independently of each other. The EGRCS implement a Parallel Rural Community Curriculum (PRCC) similar to Flinders RCS while the NVRMEN program at Bendigo and Mildura splits the year in two semesters with one more hospital based, the other community based in a smaller rural town. In the FURCS the different sites follow a similar PRCC. There is regular contact between the AC and the CE’s at the different PRCC sites. The relationship between the PRCC sites has been described as a “franchise” with balance between central control to maintain uniformity but the necessary autonomy at each site to allow for contextual differences. Administrative staff also attends the monthly meetings.

The administrative staff at EGRCS expressed the need to communicate regularly with their counterparts in the other RCS’s. The Director at Mildura RCS specifically expressed the need for more university appointed clinical educators to share his load.

Both at EGRCS and Mildura RCS frustration has been expressed at the lack of opportunity for the rural educators to give input into the year 4 curriculum and summative assessments. The impression was that the curriculum, teaching methods and examinations are still very much centrally driven with little recognition of the contribution that the RCS’s could give. In the FURCS with the AC also head of the year three and four programs, the contribution of the RCS to the curriculum is now entrenched. The rural CE’s also have input in to the yearly examination preparation. At both Monash and Flinders administrators requested yearly visits by the Heads of Clinical Departments (HoD) e.g. Pediatrics, O&G and Psychiatry to the RCS’s sites to familiarizes themselves to the learning contexts of students.

The Director at Mildura RCS has been adapting teaching methods and assessments in the program in the following ways:

- Changing form the Mini Clinical Report (MCR) to Observed Clinical Encounter (OCE)
- Changing from problem based learning (PBL) to structured tutorials
- Including orthopedics and anesthetics in the hospital rotation
- Long clinical scenario; a chronic patient followed over time
From the above discussions the following differences between Monash and Flinders emerge.

1. **Locus of control.** At Flinders RCS there is a more central locus of control with cohesion between the RPCC sites while at Monash each RCS functions independently.

2. **Communication patterns.** At Flinders there is a regular communication between the PRCC sites whereas at Monash the different RCS’s staff expressed the need for more communication and collaboration between the RCS’s.

3. **Academic appointments.** At Monash the academic appointments are the Directors of the RCS’s while at Flinders RCS apart from the Director and Academic Coordinator GP’s at the PRCC sites are appointed as 0.2 FTE’s.

**Theme 2: Sustainability**

Concern had been expressed at Monash that the RCS’s are very dependent on individuals who initiated the programs, the champions (or “nutty enthusiasts” as JR calls them), at all the sites and that these individuals are nearing retirement without clear succession planning. The GP tutors are also mostly in their fifty’s. At one site in the EGRCS a younger GP tutor has expressed frustration at her struggle to be included in the teaching of students (Orbost).

At Flinders when the champion of the PRCC (PW) became Dean of FMS he was replaced by a new Director of FURCS and an Academic Coordinator. Although they are physically far removed, they maintain a close working relationship. The leadership has changed to a more collaborative style; “I don’t do, I do symbiosis, I enable” (JG). The responsibility of the RCS seems to be more evenly distributed among the Director, the AC (both fulltime) and the CE’s (0.2 FTE) and not so dependent on one individual. At Flinders the RCS can now draw on 12 years of experience and the FURCS has been able to build up a strong core of rural educators through faculty development.

It is recommended that the sustainability issue at Monash be addressed through faculty development.

**Theme 3: Selection of students**

In the programs reviewed there are different ways of student selection:

Mildura RCS: Students at Mildura are part of the Extended Rural Cohort (ERC) who are selected on admission to the medical school on condition that they spend all three clinical years(years 3-5) in the NVRMEN region. The first 4th year ERC students started in 2010.
EGRCS: Students apply on a voluntary basis. All places have not always been filled. In 2010 not all the places were filled and some students were asked to go to EGRCS. GMS (Gippsland Medical School): In 2010 the GMS had the first cohort of 3rd year students. Some of these students from GMS were placed in the EGRCS with undergraduate Year 4 students from Monash (Clayton) medical school in 2010 – the first 3rd students from GMS.

FURCS uses a student led process in Year 2 to allocate places in Year 3. Five students choices are captured in order of preference and a computer generates the placement in order of student preference. There are 12 possible choices. Seventy three percent (73%) of students get their 1st choice and a further 14% their 2nd choice. However, the different PRCC sites are involved in deciding to which practice the students will be allocated at that site.

Riverland PRCC: Four “rural origin sub quota” students are selected into the medical program annually by a selection panel that includes local community members and local faculty. These students commit themselves to spend their 3rd year in the Riverland.

There was a clear difference of opinion between those who favored the student led computer generated allocation and those who favored local involvement in selection. Those who favoured student led selection argued that the PRCC program has sufficiently matured to accept any student. The program has the ability to identify students with problems early and can deal with it in a mature way. “It is not about screening but about recognizing problems early” (LW).

Those who favored involving the local faculty, administrative staff and community members in the selection argued that some students are not suitable for rural placements. During interviews for placement in different practices at the PRCC site, some students are identified as clearly unsuitable for rural placement. It is argued that this initial impression is substantiated in practice. “One “problem” student can taint the whole program.” A further argument advanced was that the FMS tutors are full time university employees and are expected to teach and mentor students. The GP tutors are not, a “problem” student can take a huge amount of time and energy. An (Adelaide) student who discontinued the program suddenly, left the involved GP practice with a very negative feeling. When practices interview students it becomes a commitment from both the practice and the student to make it work. In this case, the implicit agreement was unilaterally broken.

An alternative proposal was that a larger number of students should be selected for a PRCC site through the computer system e.g. 15 students and that this number should be reduced to the number of available places e.g. 10 through local selection.

The following points also emerged from the interviews:

- Students in the EGRCS felt that the places were not sufficiently advertised/promoted as they were under the impression that all places were taken.
• The community members involved in this selection highly valued their inclusion in the selection process. (Rural origin sub quota, Riverland PRCC)
• It has become clear now that in the FURCS some students do not choose the RCS option because they want to “go rural” after qualification but because they see the PRCC as a better educational model.

It is recommended that a similar approach as the ERC in the NVRMEN be implemented in the GGT where students have the possibility of doing their 4th year at Mt Gambier.

Theme 4: Students’ experience

The students’ experience was very positive and the following expressions were abundant; “hands-on”, “one on one tutoring”, “wide spectrum of patients”. The following points further illustrated the value of the students’ experience in the RCS’s;

• Students highly value the administrative support they receive; “they [the admin people] care”.
• The lack of competition for hands-on experience with other students, interns and junior doctors as at city hospitals enhances students’ learning experience. At the more hospital based sites i.e. Mildura and Mt Gambier competition was more of a problem.
• Students become part of the local health care team and feel valued as contributing members.
• Students have the opportunity to have continuity with patients, seeing the same patient in different health care settings e.g. clinic (practice) and hospital but also socially. A possible down side of this is the lack of anonymity students experience in a rural setting. A prime example of continuity is where students are able to follow a pregnant patient from early pregnancy through delivery into post natal care and child care. In Orbost students are able to attend to a number of pregnant patients through the year. Here, to be able to attend the delivery, the student is expected to have bonded with the patient before delivery. In some practices, continuity with patients is random, in others an effort is made to promote continuity. In some practices, patients are booked primarily with students.
• A highlight of students’ experience was being involved with child birth.
• Parallel consulting with the GP tutor allows students to see their own patients. Generally at the beginning of the academic year, the new students will observe patients for the first 2 weeks and then start to see patients on their own. However, it differs from practice to practice and depends on the student, the GP and the patient. At one site, after 4 months a student was not yet allowed to parallel consult to the frustration of that student. This appeared to be an exception with most students parallel consulting after 2 weeks.
• Relationships with patients, staff, mentors and the community contribute hugely to the positive experience of students. “Here everyone knows me and I know everybody if not their names then their faces” (Student, GGT PRCC).

• Students initially experience anxiety with the parallel curriculum but as the year proceeds become more comfortable with it. Students are able to identify gaps in their knowledge and experience with the help of the tutors and arrange for extra experience to fill these gaps. “Here I can create a curriculum for myself”. (Student, GGT PRCC).

• The PRCC experience is much more than the academic experience. Students have a real life experience. An illustration of this is where students experienced conflict among themselves around their after hour roster. The students were allowed to solve the conflict themselves with minimal guidance from the staff.

• The PRCC allows students to get a “taste” of rural health services without necessarily making a commitment. One urban origin student known by staff as the “city slicker”, chose the PRCC for this very reason. His rural experience opened up the option of considering a rural career.

• The student’s experience of the PRCC is influenced by the student’s future career aspirations. Some students clearly indicate that they want to specialize and work in the city. Staff experienced these students to be less committed to the rural exposure.

The students’ attitude towards the PRCC educational model were very different between the sites where it has been well established (EGRCS and FURCS) compared to the site where it was newly introduced (Mildura). At FURCS students often saw the PRCC as a preferred educational model and the credibility of the model is well established. At Mildura students were still very unsure whether the integrated model provides an equivalent educational value to the specialist based model. Some questioned the quality of the GP teaching. Students expressed concern at the emphasis on General Practice; “they want to make us all GP’s”. The uncertainty around the program is probably due to the novelty of the program. The question arises whether this is also partly due to the hybrid model. Is the GP still the main mentor in this model? See discussion Theme 9.

**Theme 5: GP tutors**

“they do it as a leap of faith as an act of faith and the reason that they do it is they hope that there will be competent people who can come back and look after their communities when they’re not there” (GP, Riverland)

GP’s undoubtedly are at the core of the PRCC model as student educators and mentors.
Rural GP’s have now earned the respect of their specialist colleagues in academic hospitals through the excellent academic results obtained by students taught and mentored by GP’s.

Some GP’s have become expert medical educators and have been recognized as such.

Through the PRCC model the central role of the GP’s in the health service in rural areas has been recognized.

GP’s express how the opportunity to become involved in education has given them a new lease in their professional life. Statements like “they keep us on our toes” were often heard. “It’s great to be able to not just do your own job but you can actually teach as well like that’s something different you can do, it's enjoyable, it’s, keeps you interested otherwise you could feel sort of I guess, getting behind or getting bored”(GP, EGRCS). “It's my job to give back to Medicine, so I’m happy to do the tutorials but I don’t want to be paid for that work”(GP,EGRCS). One remote doctor (at Orbost) considered relocating to the city with his family after 30 odd years in the same practice. He however decided to stay in Orbost during the week and commute every weekend to Melbourne (~500km) to join his family who relocated to Melbourne. His decision was because of the satisfaction of being involved with student education. “Students make my day; it is why I stay here” (GP, EGRCS). The student learning centers in the GP clinics have also benefitted the GP’s who can make use of the internet and other resources.

The question arises whether GP have been taken for granted in the PRCC model.

- Some GP’s expressed concern that they are being overloaded with medical students and GP registrars. Because of the success of the PRCC as educational model, there is pressure to add more students to sites and to open more sites.
- A further concern was that the payment has not been adjusted and that it does not cover loss of income due to the student tutoring.
- It must also be recognized that not all GP’s are interested in teaching. As one GP put it: “in a practice of 6 you would probably find two keen GP’s, two who go along with teaching and two disinterested doctors”.
- Concern has been raised over whether GP’s receive appropriate academic recognition. One limitation is that GP’s often do not have the research record/output required for academic recognition. The opinion was expressed that research should not be a requirement for academic recognition for rural GP’s.

The Flinders model of creating 0.2 FTE posts for GP’s as clinical educators allowed GP’s to become “academics” while still being able to practice 4 days in the week. It was not clear whether the designation of GP supervisors at Monash (one GP in a practice who takes responsibility for the students) was an internal arrangement in the practice or a university decision. The GP registrars in practices with one exception (Lake’s Entrance) were not involved in the student training. At Mildura Hospital registrars in other disciplines e.g.
Theme 6: Administrative staff

It became abundantly clear that the administrative staff play a vital role in the success of the RCS’s. Their commitment, enthusiasm and passion to make the program a success is remarkable. Especially the following aspects of their work need to be highlighted:

- Their logistical support to the students in providing accommodation, transport, internet access, etc. Extra mile examples are: helping a student to get a driver’s license, arranging for advanced driving lessons (kangaroo danger in the GGT), arranging basic car maintenance lessons by a local mechanic. The following quote from one of the administrators illustrate their attitude: “There is always milk in the fridge for the students”.
- Their support goes beyond logistics to pastoral care, to provide a nurturing environment. They make an effort to build supportive relationships with the students.
- Finding out students’ sport and extracurricular activities and interests and matching them up with community members and organizations.
- Flexibility in organizing the student program. Arrangements often have to be changed at the last minute due to unavailability of tutors. “We start with a draft program and we end with a draft program!” When students miss a tutorial, they make an effort to arrange an alternative tutorial. “we are so well supported, if we miss a session they will arrange another session”(Student, Riverland, PRCC).
- They are responsive to student feedback e.g. when students give negative feedback on a tutor this will be acted upon.

My impression from the interviews and my experience of the program is that the administrative personnel are truly the unsung heroes of the program.

In the Monash program the designation of academic coordinator is different to that of Flinders. The academic coordinators at Monash are academic appointments (Marnie and Loy at EGRCS and Howard at Mildura) and have a nursing background. In addition to being responsible for the daily rosters and management of students, they are also involved in tutoring of students e.g. emergency care.

In the FURCS the admin staff is purely admin. At Flinders it was commented that the divide between academic and administrative staff have been bridged with all working together as a team. The administrative staff at Flinders is encouraged to further their studies and some former admin staff have now become researchers.
Theme 7: Specialists other than Family Physicians/GP’s

Specialists do play a vital part in the RCS’s. However, the balance between specialist input and GP educator still seems to be elusive. This is made more problematic by the scarcity of specialists in rural areas especially pediatricians, O&G and psychiatrists. Students value the input from specialists. Exposure to specialists differs in the RCS’s. In the EGRCS students are allocated one day a week to a specialty in addition to two academic days and two GP practice days. In Mildura (NVRMEN) during the 6 months that students are based at the regional hospital, they spend two days attached to a specialty department in the hospital, one day in GP practice and two academic days per week. In the FURCS program specialists are included in the tutorials on the one academic day per week. Sessions with visiting specialists are arranged when they visit the PRCC site.

In the Riverland there is only one specialist left, the O&G specialist, after both the surgeons and anesthetists left. Specialist input is therefore mostly provided by visiting specialists, often from the academic city hospitals. In the Riverland, visiting specialists from FMC enthusiastically provide clinical tutorials to students, attend faculty meetings if possible and act as a link to FMC. The availability of psychiatrists is especially problematic at some sites. Students at the EGRCS at times need to travel an hour and a half to attend sessions with a psychiatrist. Students do attend consultation sessions with specialists as well as theatre sessions in the surgical disciplines where they are allowed to assist. Registrars rotating in regional hospitals are involved in student teaching e.g. Mildura and Mt Gambier.

Some specialists are very committed to the PRCC model and allow students to parallel consult, notably the pediatrician at Sale and the visiting surgeon at Barossa. Other specialists will only allow students to observe (the O&G in Mt Gambier).

Specialists attitude towards the integrated curriculum also differ. Some specialists are happy to provide patient based clinical input in consultation sessions in addition to the structured PBL sessions. Other specialists still want to “own” the curricular input in their discipline and insist on a minimum number of didactic lectures to “cover” the important factual input (the ophthalmologist in Mt Gambier). Examples of student feedback on these didactic lectures were “boring”, “40 slides in an hour, cannot take so much knowledge in”. The balance between specialist input and GP educators will most probably be an ongoing dilemma but should be actively debated and innovative solutions pursued. Is the scarcity of specialists and also of procedural GP’s a threat to the PRCC or should GP tutors take on more “specialist” tutorials?

“specialists must make shift from central role of owning the curriculum, they must be "taught" the GP role of facilitating learning; the students own the curriculum and GP's facilitate the learning” (AC, FURCS)

“this is a metaphor in terms of how the students learn in this model, is from generalists and have their learning topped up by specialist input, which is essentially reflects the same way that we deliver health care in this region” (Director, EGRCS)
Unhappiness was expressed by some specialists that they are not remunerated for time with students in their consulting rooms similar to the GP practice incentive program (PIP). Some specialists in the PRCC expressed dissatisfaction with the reduced exposure to students and therefore lack of continuity with students.

**Theme 8: Research**

The PRCC has achieved academic credibility through the success of the educational model. However “educational credibility will have to be followed by research credibility” (PW). Research that inform rural health care is therefore of crucial importance. However, the sentiment “that busy clinicians do not have time for research” is so strong that it was felt that academic recognition and promotion for rural GP educators should not depend on their research output. (See Theme 5: GP tutors).

Attempts to address this dilemma include:

- Appointment of research staff at the EGRCS
- The appointment of a Director of research at FURCS
- The appointment of GP clinical educators in a 0.2 FTE post (FURCS) with dedicated academic time for research

Further suggestions mentioned were:

- In the GP training pathway there is a research option for a 6 months full time or a 12 months part time academic post to do research. At present this depends on whether the research project is approved. The suggestion was made that each PRCC will have a guaranteed research post for a GP registrar. Changing the current MBBS to a MD requiring a research project. PRCC students will then do their research in a rural community to the benefit of that community. This will increase the research output of the RCS and will enhance the research culture in the PRCC.
- Students have the option of doing an extra year to obtain a B of Med Science.

It is recommended that Monash explore the possibility of appointing GP supervisors in practices as 0.2 FTE similar to the flinders model to allow for dedicated research time.

**Theme 9: The Parallel Rural Community Curriculum (PRCC)**

The PRCC model is now accepted as a very successful medical educational model. The pillars on which this model stands are:

- Integration of the different specialties ; “turning the curriculum on its side”
- Immersion in a community for one year
• Continuity with patients, their families, the mentors(GP’s) and the community
• Experiencing working in a team with other health care professionals

The key motivation for the PRCC was to address the rural workforce shortage. To what extent the PRCC has addressed the rural workforce shortage will be discussed in more detail in Theme 14: Recruitment and Retention. However, the PRCC model has now become an integral part of the medical schools. Moreover, with the increase in medical students, the medical schools cannot teach additional students without the placements provided by the RCS’s. At Flinders MS the RCS funding kept the medical school afloat when traditional funding was reduced.

Flinders University Medical School is a graduate entry program. Students are allocated to the RCS in their 3rd year, the first clinical year. Since the establishment of the Riverland PRCC the model has been duplicated in three more sites in the FURCS i.e. Greater Green Triangle (GGT) (Mt Gambier), Hills-Mallee-Fleurieu and the Barossa valley. Although these sites differ in the distance from the FUMS and in their rurality, the PRCC programs are very similar. THE GGT PRCC differ in that at Mt Gambier there is a regional hospital with specialist care as well as the ability to take 4th year students and interns.

Monash Medical School is an undergraduate program. Students start clinical training in their 3rd year with hospital-based rotations in surgery and medicine for 6 months each. Selected students do their 4th year in one of the four RCS’s in the School of Rural Health, Monash, namely East Gippsland, Gippsland, Bendigo and Mildura. The latter two work together in the so called NVRMEN (Northern Victoria Regional Medical Education Network). EGRCS and Mildura RCS’s were part of the review. (The reviewer independently visited the Bendigo RCS after the review.) The EGRCS follow a model similar to the Flinders PRCC with attachment to a GP practice. The NVRMEN model is a hybrid between the traditional specialist rotation and the PRCC model. Students spend 6 months at a regional hospital (Bendigo or Mildura). During this time their week is divided as follows; two academic days, one day attached to a GP practice and two days attached to a specialist department at the hospital. The 18 week semester is divided in three 6 weeks blocks between the three specialties; O&G, Pediatrics and Psychiatry. The other semester the students are attached to a GP practice in a small town with two academic days, two GP days and a community day. The 4th year students allocated to the NVRMEN are divided into 2 groups. One starts with the hospital based program, the other with the GP based program and they change midyear. All the GP attachments are administered from Bendigo. In this model students therefore spend two 6 month periods in two different communities.

It begs the question whether the hybrid model compromises the pillars of the PRCC model.

• The curriculum is not truly turned on its side as the specialist block system is still maintained to some extent.
• Continuity with patient, mentor and community is for 6 months instead of a year and so is the attachment to a team. However, the GP based part of the
program is very similar to the PRCC model. This hybrid model was only instituted in 2010 in the NVRMEN.

- As mentioned in Theme 4, students at Mildura were still skeptical of the educational quality of this model, especially the GP input. However, the GP based part of the program is very similar to the PRCC model. Students did not seem to regard their GP mentor as their main mentor.

Is the tension between specialist and GP input into the program at the heart of this hybrid model? Is this model to some extent returning to a specialist based curriculum? Has more specialist input been the motivation for the hybrid model? Or is it rather a pragmatic practical arrangement? For 6 months the students are hospital based with a one day GP exposure, rather than GP based with specialist input on occasion. Who owns the curriculum here?

There are many different pathways to the same goal, with an inclusive curriculum based at all sites. However, students will experience this curriculum in many different ways in the different contexts. For example, students’ experience of gastro enteritis in the Northern Territory will be very different from students in Adelaide. It is important to evaluate the two models in terms of both the educational model and the effect on rural workforce.

The GMS (graduate entry) allocated 3rd year students from 2010 to clinical rotations in EG and GRCS as well as a hospital in Melbourne with GP attachments. I am aware that the GMS have initiated an evaluation of the 4th year at Monash across all four campuses i.e. Monash, GMS, School of Rural Health and Malaysia.

Students now choose the RCS because they see the PRCC as a preferred teaching model, not necessarily because they want to become a rural practitioner. Does this threaten the original motivation for the RCS i.e. to address the rural workforce shortage? Does the success of the PRCC as educational model dilute the workforce motivation?

Another difference between the PRCC models in Monash and Flinders RCS is the use of logbooks. At Monash logbooks are used for the following reasons;

- As a record of a student’s learning activities,
- To encourage students to monitor their own learning activities,
- To monitor hurdle requirements
- For formative and summative assessment
- It gives students the option to include interesting activities
- Allows them to reflect to what it extent it addresses learning objectives
- Allows them to identify gaps in experience and to address these

In FURCS, logbooks are not used. It is argued that a clear distinction should be made between the logbook as learning tool and as an evaluation tool. Recording the number of conditions seen or procedures done does not necessarily reflect the quality of the experience.
The PRCC model has brought new enthusiastic (GP) educators on board that has now been recognized in the Medical Schools for their leadership role e.g. the AC at FURCS (LW) who heads the year three and four program at Flinders MS. The AC also acts as bridge between the CE’s and the University and negotiates additional input by specialists from FMS where necessary.

It is recommended that the different educational models at Flinders and Monash be evaluated for the effect on educational outcomes as well as the rural workforce shortage.

**Theme 10: Community immersion**

“there is no way of separating yourself from your patients in a small community at all, so I certainly talk to students about the fact of living and working within the community and how important it is to keep good relationships with everyone” (Nurse, EGRCS).

The immersion of students in the community for a year is a vital part of the PRCC experience. Without it the PRCC will just not be the same! Students become part of the community through living in the community and taking part in community activities especially sport and community organizations e.g. service organizations. Students do not only see sick people but experience health and disease in a community setting and also become aware of the particular occupational hazards in that setting. The quality of this experience depends though on a number of factors:

- In smaller communities the immersion is often easier, more intense.
- The distance from main campus plays a role especially when students have partners or close family ties in the city. The shorter the distance the easier to commute back to the city during weekends. “it is much further from the city to the bush than it is from the bush to the city!”.
- The quality of community immersion depends a lot on student attitudes. There were some wonderful examples of student immersion in communities with long lasting friendships formed. “This is home right now” (Student, GGT). However, other students were hardly seen in the community other than on their “GP days”.

At FURCS there is a Marg Brown Community Engagement Award each year for medical students. This gives recognition to students who made an effort to become part of the community. In the FURCS students are expected to do weekend calls, usually one in 3 to 4 weekends. This is not required from students at Monash. Spending weekend time in the community may assist students to immerse in the community.

It is recommended that at Monash students are required to do weekend duties both as an educational experience and to enhance their community engagement.
Theme 11: Inter Professional Education (IPE)

During the Monash part of the review, the reviewers interviewed some of the nursing professionals involved in the medical student training e.g. a psychiatric community nurse in Bairnsdale and the community health nurses in Orbost. During the Flinders part of the review we interviewed allied health workers in the Riverland and the GGT PRCC. We also interviewed a private audiologist in the Barossa PRCC. Hospital nursing managers were interviewed in Bairnsdale, Mildura and Mt Gambier.

It became clear that the nursing staff both in and outside the hospital context enjoyed the students, found them friendly, enthusiastic and stimulating. The community nurses can add tremendous value to the medical student training. Two outstanding examples were the psychiatric nurse in Bairnsdale who took students on home visits and involved them in the low care facility. The community health nurses at Orbost Medical Centre were very involved in the students experience especially in midwifery care, from ante natal care through delivery to post natal and child care. This provided an excellent example to the students of inter professional teamwork. The nurses were so involved with the students at Orbost that they felt they should also be included in the practice incentive program (PIP)!

“…student involvement is mutually beneficial, that’s how I see it, I reckon it’s not just them learning it’s us learning too”

"I've never had any negativity about nurses teaching the medical students or being involved in their training or anything" (Psychiatric nurse, EGRCS)

In the Monash RCS’s students were not required to spend much time with Allied Health Professionals (AHP). In the FURCS students are required to do a set number of sessions with allied health workers. Students are required to arrange these sessions themselves. Feedback from the involved AHP’s was that due to their busy schedules the medical students often leave these sessions until the end of the year. The AHP would prefer that specific times be scheduled for these sessions with them. This will give them time to prepare, to not only expose students to clinical work but also involve students in their community projects.

Extending the PRCC model to allied health at the present PRCC sites, opens up a huge potential for medical and allied health students to partake in IPE and experience inter professional team work during their training. This is certainly an important further development in the RCS and the PRCC.
It is recommended that more structured IPE sessions be included in the PRCC.

Theme 12: Community engagement

As mentioned under Theme 6: Administration, the admin staff put tremendous effort into activities to introduce new students to the community and to make the community aware of the PRCC program and the students’ presence. Every year a welcome dinner is organized to introduce the students to the community. In Mt Gambier this is sponsored by the local council and students meet the mayor. Allied health workers and community nursing staff that work with students are invited (they appreciate this and feel left out if not invited!). The local media is used to profile the new students and each facility has photos of the students with their names.

A program of community contact persons is also operating in the communities where students are situated. Community members volunteer to “look after” specific students during the year, to introduce them to community organizations e.g. Rotary. Students are encouraged to join the Young Professionals Society in each town. In interviewing community members as well as staff it is clear that in some instances the community contacts program works tremendously well with lasting relationships developing between students and their contacts. However some students prefer to build up their own contacts or do not see the need for such a program. Some students do not initially take up the offer but do after a few months. The potential of the community contacts program is undeniable but it has to be introduced with sensitivity to the students needs.

It is remarkable how willing patients are to be seen and examined by students. They feel that they are contributing to the development and training of doctors to be, but they also have the expectation that these students will come back to their community. “I really like having a student with me, it makes me feel that I've given back to the community”(Community member, GGT). Concern has been expressed that community members are not aware of the long lag time before these students have the potential to come back to rural areas. Another concern was that if the PRCC is unable to deliver on the expectation of the community that the students will come back once qualified, the community goodwill will diminish.

Several examples were mentioned were the medical students became role models for scholars in the community, opening their eyes to the possibility of a university education and/or a health care career.

Theme 13: Faculty development

The Riverland PRCC started off with GP’s saying “we cannot teach, we are only rural GP’s”. Now some of these GP have become experts in medical education. In the FURCS there is now sufficient educational expertise among GP’s to organize their own annual workshops. A Masters/Certificate in Clinical Education is available and
for GP’s that do register, the benefit is huge. However desirable it is that GP’s should attend medical education training, it is not only available time that is the limiting factor but also loss of income when they attend workshops. Several suggestions to address this dilemma have been proposed e.g. proper financial reimbursement for time spent away from the practice. The natural ability and inclination of many rural GP’s to teach should be recognized and enhanced. Faculty meetings for clinical educators are in effect faculty training when experiences with students are shared among the GP educators. These meetings involve experienced academic educators.

**Theme 14: Recruitment and retention**

Common responses to the effect of the RCS’s on recruitment were: “not yet”, “too early to say”, “We don’t know”. The Monash RCS program has only been in operation for 6 years therefore it is too early to judge the response. Figures of 60-70% PRCC students returning to some rural location was quoted in the FURCS program. There were some anecdotal stories of students who returned to the PRCC sites where they trained as medical students. The best example is probably the ex-PRCC student from the Riverland who is now the clinical educator in the Riverland PRCC. However, one does get the impression that communities feel that the program has not yet lived up to their expectations. There has been general consensus on the following:

- The PRCC exposure sensitizes students to rural health services and opens up the option to consider a rural health career.
- Even if students do not return to a rural setting they will have a better understanding of the challenges rural patients and rural health services face.

There was also consensus that involving GP’s in medical education enriches their work experience in rural areas and helps to retain them. The creation of academic posts in rural areas also attracts doctors and rural hospitals that are now known as teaching hospitals e.g. Mildura and Mt Gambier, can use this in recruiting doctors.

One problem is that students go back to the city after their 3rd year to do their 4th year and then the intern year. There is thus no continuity of rural experience. The exceptions are Mildura and Mt Gambier where students can do internship and possibly their 4th year as well. The Extended Rural Cohort students in the NVRMEN (Monash) spend all three clinical years in the RCS.

The new MSOD computer-based system across Australia will in future help to track students and provide statistics on the career pathways of students.

**Theme 15: Aboriginal Health**

Aboriginal health did not feature much in the review. The exception was EGRCS where one of the faculty members has a special interest in Aboriginal health. Students in Bairnsdale do attend Aboriginal Health Services but not on a regular
basis and therefore do not experience patient continuity. It is recommended that an effort be made to involve students on a more continuous basis in AHS.

**Theme 16: Inter university co-operation.**

In the FURCS, the Barossa PRCC shares students between Adelaide Medical School and FMS. Feedback from students and administrators is that the students work very well together in the different practices. However differences in practical arrangements e.g. accommodation and ITC, necessitates that students form the two medical schools use different accommodation. Differences in the academic programs make it difficult for students to share academic activities. Students for Adelaide are in their second clinical year unlike the Flinders students who are in their first clinical year. While initially the Adelaide students slotted in with the Flinders academic program, the academic programs are now run more separately with the academic days virtually separate now. The difficulties inherent in sharing two very different academic programs became more apparent as the program progressed beyond the first year. It is recommended that the two RCS’s relook at how the two academic programs could be integrated.

This review is an excellent example of interuniversity cooperation in that the two medical schools jointly commissioned the review with the express purpose of comparing the two programs and learning from each other.

**Concluding Personal reflection:**

Being part of the review team, has given me a wonderful opportunity to interact with so many of the role players from Deans to students in the RCS’s at Monash and Flinders. The experience gave me deep insight into the educational models and curricula, the personnel structure and administrative arrangements in the RCS’s I visited. The Stellenbosch University, Health Sciences Faculty, is starting the Ukwanda RCS in Worcester in 2011 with 9 students. The insights I have gained in rural medical education during the review have been and will be invaluable in my role as the academic coordinator for the Ukwanda RCS responsible for the academic program. My sincerest appreciation goes to the Directors of RCS’s of Monash and Flinders who have invited me to be part of the review. Be assured that you have contributed in no small way to the establishment of the first RCS in South Africa.
Recommendations:

The following recommendations are suggested:

1. That Monash explores the possibility of appointing GP supervisors in practices as 0.2 FTE similar to the Flinders model. This will allow dedicated research time for GP supervisors and has the potential to address the sustainability issue by involving more GP’s in faculty development.

2. That Monash explores the possibility of more regular communication between the different RCS’s in the Monash School of Rural Health.

3. That Flinders explores the implementation of a similar approach as the Extended Rural Cohort in the NVRMEN in the GGT where students have the possibility of doing their 4th year at Mt Gambier.

4. That the different educational models at Flinders and Monash be comparatively evaluated for the effect on educational outcomes as well as the rural workforce shortage.

5. That at Monash students are required to do weekend duties both as an educational experience and to enhance their community engagement.

6. That more structured Inter Professional Education sessions be included in the PRCC.

7. That an effort be made to involve students on a more continuous basis in Aboriginal Health Services.

8. That Flinders and Adelaide Medical Schools revisit the sharing of the Barossa PRCC and how the two academic programs could be integrated.
A Comparative Evaluation of the Flinders University Parallel Rural Community
Curriculum and its support programs with the community-based medical
programs of Monash University East Gippsland Rural Health School.

Professor John Halsey
Sidney Myer Chair of Rural Education and Communities, Flinders University

Purpose
The Flinders University Social and Behavioural Research Ethics Application
documents states that the comparative evaluation “aims to explore the depth and
breadth of student experience and determine any gaps which need to be
addressed… [and that] the evaluation will investigate the major relationships that
contribute to good outcomes for students, clinicians, health services, the community
and the government”.

Two key questions were agreed to focus the evaluation, namely:

1. How successful is the program in preparing students for future practice?
2. How does the program address the rural health workforce shortages?

Evaluation data
Evaluation data was collected through a wide range of one-to-one and focus group
sessions of approximately an hour’s duration, as far as possible conducted in the
learning-teaching contexts of participants, using a semi-structured interview
methodology. In most instances interviews were recorded and transcribed verbatim
and/or extensive field notes were taken by the evaluator, including where
appropriate, direct quotations of participant responses to questions or points made
during discussions. As well, data was made available for the evaluation through a
survey of students in the Rural Clinical Schools.

Evaluation Report Structure
While the definition and purpose of evaluation remains problematic for some and can
embrace concepts such as assessment and investigation, for the author, evaluation
is primarily about determining the merit of something, particularly in relation to either
endorsing an approach or program or identifying areas for improvement.
Given the aims and 2 key questions of the evaluation, this report is structured around 6 commentary and feedback organisers, namely:

- students and their learning
- teachers and teaching
- curriculum
- community and partners
- administration and support
- leadership and management

The comparative dimensions of the evaluation are referred to as appropriate in each of the feedback organisers and in the discussion sections of the evaluation report. The extent of treatment of the feedback organisers varies extensively; this in no way relates to perceptions of importance in relation to the ‘whole picture’ of the rural medical programs.

**STUDENTS AND THEIR LEARNING**

*Students and their learning- quality*

Both the Flinders (referred to hereon as F) and Monash (hereon referred to as M) programs provide students with intense, rich, and deeply rewarding learning opportunities and experiences. This came through consistently in all of the interviews conducted with students, even those who entered into one version or another of rural medicine with either some degree of hesitation or scepticism about the quality and rigor of what they thought their learning would be, compared to remaining within the main academy in the respective capital cities. The following comments from students form the basis for the claims being made:

“…one thing that strikes me that’s unique… is the integrated program where we’re cycling through all the specialities… I personally think that’s a great system because it’s much more real and it’s [a] better educational tool…”

“Last year I was at Sale… I got a lot out of it… the teachers had a lot of time for us… impressed with the facilities and their style of teaching as well so I decided to come out here this year… so far it has not let me down”

“… heard about the program from other students and it seemed to be very well and have really good hands on opportunities… I find one of the big advantages is with the
patients that are willing to get involved [in my education and training] because they
do want you to have a good experience and come back…”

Q- “how do you respond to the view that the rural placement model is an easy cop
t out because you do not get any depth- you’re just dancing across the top of the water
like a mosquito?”

R- “Well we’re not training to be specialists in this point of our medical education…
even if you’re in a specialist tertiary centre, you’re not training to be a specialist yet,
you’re training to learn how to speak the language, to actually navigate your way
through the system and for those purposes, the depth to which our education goes is
adequate enough I would argue”

“You actually feel as though you are part of the team…you feel like you are not a
burden to people, it’s an amazing difference… my last year at the Alfred and here,
you’re actually part of the team and you’re not sitting there like a fly on the wall,
you’re actually doing things and the fact we’re able to do hands on stuff here”

“[Here] you can actually have something to do with the doctors… you can sit around
and talk with them… at the Alfred you went through interns or the registrar and you
wouldn’t go out for coffee with them afterwards, but you would here”.

Interview 100409 [M]

“One of the reasons I came to PRCC was because of the likelihood of getting greater
access to specialists and the learning generated by being able to do this”

In the PRCC learning context “you can ask dumb questions and not feel bad- [I] do
not get stressed”

“The Clinical GP model of teaching is very important- you need [to have] someone
who can pull everything together- I do not need a horsewhip or trophies- I need to
know I am doing well- on the right track”

Author’s field notes, April 29 2010 [F]

“Very hands on; very good supervision, a great range of learning, open opportunities”
“[I] do not get lost in the system- there is a lot more 1 on 1 consultant time- ideal set-up if you want to be a GP and I also get to see acute cases”

“I want to be a physician but I do not feel I have been disadvantaged by being here”

“PRCC gives you an opportunity to see what country work and life is like without the risks”

“PRCC really forces you to identify what you need to learn”

“[I] love getting out of bed and not knowing what the day will be like for me- people grab you to see things- we feel valued”

“At Flinders I always felt in the way- I don’t feel like this out here”

*Author’s field notes, 30 May 2010 [F]*

**Students and their learning- co-constructors**

In light of the very positive comments made by students about their learning journey to become medical doctors, it is necessary to enquire more deeply into what is going on and why. Before doing so it is important to acknowledge the crucial dispositions and framing factors that medical students bring to their learning which likely impact on the positive views being expressed by them. These include their maturity and strong sense of vocation; their success to date and the impetus this provides to continue to be seen by teachers and peers as a successful student; the fact that the profession they aspire to is widely considered to have the highest or near highest status of any of the recognised professions; the extensive support each receives by way of accommodation and connections into communities and the like which leaves them relatively free to focus on study; and the esteem support staff generally hold for the students.

The key to understanding the widely reported positive evidence from students about their rural experiences lies in the way they are able negotiate and construct their learning, and as appropriate, to manage and pace it in a real world professional context- a clinic or a hospital or a specialised referral service. There are, of course,
very detailed curriculum parameters that govern what students need to learn in order to pass examinations. Very interestingly for someone who has spent all his professional life working in education where how to assess learning continues to be a very contentious and contested issue, the rural medical students in the evaluation appear to accept examinations as part and parcel of their lot. On the matter of examinations, the decision for rural based students to take the same examination as those who remain in the city based academies is a powerful, and I would argue, necessary, means of neutralising a potentially destructive course status debate vis a vis city standards versus rural standards. Related to this point, there were a few rural students who expressed some lingering doubts about whether they were getting a medical education that was at least the same as those who chose to stay in the city. I asked students what question they would ask the Monash Dean of Medicine if he visited. One student said- “is the program we are doing here [Mildura] matched up to the city/metro program?” Another said they would ask the Dean “is the weight of GP in our curriculum known by him?”

(Author’s field notes, April 20, 2010, M).

Returning to the approach to learning, the curriculum that students are required to study in terms of both universities is imbued with a strong sense of compulsion about the content which has to be covered and learnt. Balanced with this however, there appears to be extensive scope for students to shape how they cover and learn the prescribed content of topics and courses. There is also scope for students to initiate additional learning through volunteering to spend extra time in wards or emergency departments for example. As well, flexibility and a significant degree of autonomy around the how dimension of their learning seems to encourage and nurture student inventiveness and the voluntary pursuit of seeking out enriching learning contexts like a delivery ward in the middle of the night when there is an emergency. The reality for most students interviewed is this would not be an option for them in a large city context. As one student succinctly said, “there is no way you’d get a chance to in the city because there are interns, registrars, other medical students, nurses, midwives [and] trainees” all competing for limited real life learning opportunities

(Interview 100409, M).

Students and their learning- concerns

While the overall view of students from both universities about the content of what they are required to learn and the methods and flexibility to do this are strongly supported and valued, some concerns were expressed. The size and constancy of the study workload is a real pressure point for students- while not every student in the focus sessions mentioned it, when it did come up there was group acknowledgement of the matter. A student at Mildura reported the integration approach to curriculum and learning with 4 specialties up front created pressure- “[I]
had no baseline to work with; at the start did not know where to put my focus- now better” *(Author’s field notes, April 20, 2010, M)*. Another student in the same session remarked that while 4\textsuperscript{th} year “was the big year [and it] cuts down the time for community…[it was] really exciting to diagnose and manage a patient” *(Author’s field note, 20 April, 2010, M)*. The power of the real world consulting-clinical learning context for motivating students and developing and nurturing their confidence and competence was widely commented on- “[it helps in] putting things together rather than thinking we know it because we have read it”; [I now have] the ability to talk to a patient”; “[it is] really hands on- I like being involved”; “PRCC really forces you to identify what you need to learn” *(Author’s field notes, 20 & 30 April, 2010, F & M)*.

The clinical context, while very favourably reported on by students in most instances, can be problematic for others. One (Flinders PRCC) account involving a mature aged student may be illustrative of a more general issue. The student in question commented that “this year was stressful – [I] am trying to find my place in the clinic – [it was] ok at the start because you don’t know anything- but as you start knowing, frustration grows when your knowledge is not recognised…the year for me is setting me up to be an intern not [to do] the exams…the thing I find most useful is when I am given autonomy to deal with patients” *(Author’s field notes, 29 April, 2010, F)*.

A student who enters medicine from an established career which may have included personnel and large budget management responsibilities, seems to me to require tailored assistance to successfully make the transition from careerist to student. In some cases there may not be sufficient acknowledgement given to the work place maturity of students with this kind of prior experience and from this, insufficient attention to adult learning styles. Conversely it may be the case that the transition to being a student for a mature age person is a very challenging one with its high points and low points, sometimes exacerbated by looking back to what one gave up rather looking forward who one will become at graduation and registration.

A view was expressed that ‘becoming a rural GP’ message is overplayed at times and perhaps this, for some, detracts from the fact that the model of learning used by F & M is, as stated already, seen by students to be a very effective and, notwithstanding the pressures, a very enjoyable one. A student at Mildura remarked ‘stop trying to make people become GPs- make it attractive but don’t mould them’ *(Author’s field notes, 20 April, 2010, M)*.
Students and their learning- *place, space and community*

Being physically located in a rural community for an extended period of time has a significant impact on students. It is a very powerful means of asserting the importance, value and unique contribution that *place* brings to learning and the formation of self with others. The following extracts from the work of David Gruenewald (2003) provides a philosophical framing for considering *place* in medical education:

Invoking the import of place, Geertz (1996) comments, ‘[N]o one lives in the world in general’ (p. 259). A multidisciplinary analysis of place reveals the many ways that places are profoundly pedagogical. That is, as centers of experience, places *teach* us about how the world works and how our lives fit into the spaces we occupy. Further, places *make* us: As occupants of particular places with particular attributes, our identity and our possibilities are shaped”.

And:

Thus Snyder’s (1990) cogent assertion ‘The world is places’ can be extended: It is also true that people make places and that places make people.

The kind of teaching and shaping that places accomplish, of course, depends on what kinds of attention we give to them and on how we respond to them.

Although culture and place are deeply intertwined (Basso, 1996; Casey, 1997; Feld & Basso, 1996), our relationship with places has been obscured.

Further:

A fundamental paradox of place, then, is that although we can experience it everywhere, everywhere it recedes from consciousness as we become engrossed in our routines in space and time. (pp. 621-622).

Embedding high status, high stakes education in rural contexts- rural *places* - from the perspective of students, seems to have mainly beneficial consequences. For those who have never lived in a rural community before in particular, it is engagement with what Soja (1996) would call *Other* - the possibilities and opportunities of living and learning in a context where distance and population mass and density are radically different compared to large urban settings. Linked with this and drawing on Soja (1989 & 1996) again, locating students in rural contexts not only presents them with differences relating to the physical nature of places and spaces but also to the social nature and possibilities of them. It provides them with very immediate opportunities to consider how as medical practitioners in training they are also active agents in the creation of social spaces where possibilities, as yet un-thought of or undiscovered, might emerge. Soja refers to the production or construction of social spaces as *spatiality* (1989, p.80). He argues:
The dominance of a physicalist view of space has so permeated the analysis of human spatiality that it tends to distort our vocabulary. Thus, while such adjectives as ‘social’, ‘political’, ‘economic’, and even ‘historical’ generally suggest, unless otherwise specified, a link to human action and motivation, the term ‘spatial’ typically evokes a physical or geometrical image, something external to the social context and to social action, a part of the ‘environment’, a part of the setting for society — its naively given container — rather than a formative structure created by society”. (Soja, 1989, p.80).

And consequently encourages us:

...to think differently about the meanings and significance of space and those related concepts that compose and comprise the inherent *spaciality of human life* [like] place, location, locality, landscape, environment, home, city, region, territory and geography. (Soja, 1996, p1)

Numerous students from both F & M commented on how they enjoyed being in a rural community and being recognised in their role- even being referred to as doctor on occasions. The nature and character of the *place(s)* and the relatively uncontrived and free-flowing way in which social interaction occurs in the course of day to day to life, seems to be a significant benefit to students in their learning journey. One student said ‘I think its really funny that you bump into your patients in the community, one guy was a diabetic and the doctor told him off for eating chocolate...and I saw him at the pub eating mud cake with extra cream!’ (*Interview 100409, M*). Another commented ‘patients want to really get you involved [in the community] so you have a good experience and will want to come back’ (*Author’s field notes, 9 April, 2010, M*), and ‘the community is generally very positive; patients are very supportive- wonderful to see my name in a birth notice and to meet patients in the supermarket and talk’ (*Author’s field notes, 20 April, 2010, M*). As another student said ‘[a] large part of it [extended rural placement] is not just a clinical experience though, it’s also the fact that we’re living here, they do take care of us so we have a positive experience of living in a small town..’ (*Interview 100409, M*). Regular enquiries from people in the community about how things are going for a student(s), seems to be widespread in both F & M programs.

Another important benefit of being in a rural community is the opportunity it provides for students to ‘test drive’ country life without taking a major career risk. ‘...the third year in the PRCC program gives you a real option to see what country life is like, there’s no risk to you at all as an individual...if you don’t like it, you go back to the city in fourth and follow another path...’ (*Interview, FUstudent2, F*). Another perspective, the PRCC ‘gives you another environment to see if you like it or not as opposed to if
you wanted to do this after you graduated to your internship or so forth, then I think there’s more risks to you I think professionally or otherwise because you’re uprooting and setting yourself up there [country].

*(Interview, FUstudent2, F)*.

**Students and their learning - other matters**

Returning to the matter of examinations mentioned earlier, one PRCC student raised an issue with which others in the group appeared to concur. Put succinctly it is the matter of what the textbook says must be done versus what can reasonably and safely be done in a real life, time limited environment like a doctor’s surgery. In the student’s own words and referring to a previous discussion of wanting more time for extensive examinations of patients, ‘you need to watch for the possible ‘traps’ [as a student who has to pass exams] between what you do in the GP Clinical setting where time is pressured versus what you need to do for an exam- [example discussed was the text book method of taking a patients blood pressure compared to how it is usually done in a GP’s clinic].

*(Author’s field notes, 30 April, F).*

Another matter raised in a student focus group (Monash Bairnsdale group) which causes some concern is travelling for a specialist session (11/2 – 21/2 hours depending on ‘home’ location for psychiatry in this instance) to find the session not as useful- structured- as students would like. In addition, the same group of students, while expressing how valuable specialist tutorials are for them, found that the ‘video conference detracts from it a little like that whole medium detracts from it a bit [it being learning].

*(Interview100409, M).*

The composition of particular cohorts of students and the group dynamics of them appears to be relevant vis a vis the quality of the rural placement experience for students, and presumably those who support and teach them. Reading commentary by students in the Raw Data from the RCS at a meta level, there seem to be several key messages coming through.

Firstly, that which acts as a unifier of the group, the program, is also and simultaneously a powerful differentiating site/factor for the group. Put another way, the diversity of personal backgrounds of students and their present life circumstances- married, partnered or single; parent or not; embracing of the model or somewhat sceptical; relatively clear about their career aspirations or still open and so
forth- combine to create a very complex mix of factors for program designers and deliverers. An important implication arising from this for optimising students’ learning is that job of so doing is on-going, never closed or completed, and always subject to how individuals navigate and negotiate with what is on offer. A 100% match between expectations and learning needs is essentially beyond the control of program designers and deliverers. What is within their control however is the capacity to monitor and tune programs as students move through a cycle and, from this process, forward key learnings into planning and delivering for the next cohort of students.

Secondly, while there is wide spread support for both the Flinders and Monash rural programs, there is also a fairly well entrenched sense of students assessing the merit of what they are doing, against what they think their peers who have remained in the city/main academy are doing. In other words, not withstanding the perceived benefits of the rural option, the standard of teaching and learning is sometimes- often?- referenced to the larger cohort and to the main hub for the degrees. Linked with this is a sense, at least for some, that the small size of the cohort for each of the programs does not stimulate sufficient competition to drive learning. Paradoxically though, the absence of competition in relation to accessing front line hands on experiences is highly valued.

Thirdly, in relation to perceived benefits, disadvantages and suggested improvements, there are a number of important things to note in terms of improving placements in the Rural Clinical School. To extract the full benefit of the responses to the questions, it would be useful to tabulate individual student responses to each of the questions to facilitate 2 things- an overall judgment about the worth-whileness for an individual, and, more importantly, to see if there are internal inconsistencies/contradictions in their responses. As the response data stands at present, it is hard not to conclude that there is very strong support for the rural model and there are also some substantial concerns about it- there is no real way to hone each down. Notwithstanding this, my reading and my interactions with students leads me to the conclusion that both the Flinders and Monash rural medicine programs are more valued by students than not and by what I would call a considerable margin.
tensions that some students may feel between curriculum that is presented in concentrated chunks versus curriculum that is embedded and learned in context.

As for learning design and delivery, there is no doubt for both Flinders and Monash that workplace learning is highly valued by a majority of students. Having made this claim, it is also the case that some students find negotiating, navigating and managing their own learning a challenge, perhaps even a struggle. A component of the struggle appears to be related to travel, the variability of modes- face to face versus video conferencing- and the variability in the teaching and mentoring styles of staff. Another component of the struggle, related to perceptions of quality and diversity referred to earlier is concerns about the range of patients and their conditions available to students and, the range and type of specialists students interact with.

Administrative support is clearly a crucial area for determining whether an extended rural placement is successful or not from a student’s perspective, principally because of relocation to and establishment in, mostly, an unfamiliar context. From the interviews and discussions I had with students in both the Flinders and Monash programs, the overwhelming impression I gained is that students are very appreciative of the kinds and level of support they receive from administration staff, and through them, the standard of accommodation they have and the community networks introduced and made available to them. However, from the RCS survey responses, it is clear that there are administration issues that do need to be addressed, apparently more of a relational rather than structural or procedural kind. It is not possible to identify from the way the data is presented whether the responses apply to Flinders or Monash or both, or particular units within both.

**TEACHERS and TEACHING**

Reading the transcripts and reflecting on the interviews and focus groups, it is interesting to ask the question, who are the teachers in the Flinders and Monash rural based medical programs and how do they teach? The answer is not as straightforward as might be imagined. My reading of the contexts and the transcripts shows there are many and diverse teachers who teach in a wide variety of situations using a range of methods. There are also some who might be called informal teachers- like the volunteer community members who role play patients but clearly through this, teach students. As well, there are the rich teaching contexts like hospitals generally, specialist departments within them, one off events like a procedure or the opportunity to meet and listen to a visiting specialist. Notwithstanding the above, the main focus of this section is on those who directly teach rural medical students.
It is overwhelmingly the case that those involved in teaching the Flinders and Monash rural medical programs find the experience professionally and personally rewarding. However, there are also some issues and problems associated with the rural medical programs from the perspective of teachers and teaching; they range from fine tuning to ones more of a root and branch kind like curriculum design and content.

Following is evidence from the transcripts and my field notes for judgments I have made about teachers and teaching and some discussion relating to each. Some of the quotations are quite lengthy. I have resisted using précis’s of them or keywords so that readers can form their own views about the significance of what is being reported.

Positive Aspects

Quotations such as the following are evidence of how highly both programs are valued by teachers:

“… we find it a very positive part of the practice having students and …certainly support it”

“(Focus Group Transcript, 9/4/2010, M)

‘I think if we’re teaching students something that they want to learn it’s a pleasure…[for good teaching and learning] it’s essential you have good relationships with everything from the cleaner up to the maintenance staff right throughout the whole organisation…”

“…it’s a big investment in time and energy for all of the nursing staff… it’s only because of their attitude of wanting to teach and embracing the students that it does work so well…”

“It’s nice to think we could have some input into somebody else’s career path or into the way they maybe think about sickness or health…maybe the way that they practice in the future will be impacted from what we taught them or the way we treated them.”

“The turnover of students is good…within a small rural community [where you ] see the same faces every day it’s nice to have that breath of fresh air come into the place once a year.”

“…it’s nice to, it’s a challenge to train medical students, it’s interesting to see how they develop over a year. It also puts us on our toes which is good, just to know what we are talking about…”

(Orbost Regional Health, 1&2, M)

“I wanted to be involved because I saw it as a good and useful thing to do [and] students teach me things… the PRCC is an opportunity to educate good doctors using patients”

“Education is a great plus…students influence the learning outcomes of experienced staff…it is a two way process”

“Being involved with students has been very positive for my learning…”

“They are educating you just as you are educating them…”

[teaching students] makes me read and keep up to date…”

(Author’s Field notes, 29 & 30 April, 2010, F)

“it’s good for our work and it’s a bit inspiring having young people around, I mean they’re intelligent, they’re interesting, they’re enthusiastic, so I think it just, yeah makes my work a bit more interesting, and I think most people feel the same way up there.”

(Interview DJ_100409_003, M)
“I was about to leave…and I was looking around for an alternative and then the students came along and I thought that was probably the way to go…I don’t think I would have survived in an academic position…the politics and that sort of stuff just doesn’t do anything for me…I’m for the time being quite happy continuing to deliver a program [here]…”

“I love to just teach the students general practice and how to be safe and thorough and organising things like follow up and safety netting and making sure that the patients understand what you think they understand just teaching those general principles knowing that they get a much more specialised teaching on the other disciplines from all the other doctors in the clinic.”

(Interview DJ_100412_003 EGRCS, M)

“I think, one of the attractions of rural settings is that doctors that come here [South East] actually love to teach, and even our ED and our theatres, and our general medicine areas, the people that are in there love to teach rural students, and the GP’s … the same, they just – in fact, […] some] probably overload themselves with trainee medical officers, because they do like to teach; they see it as… an enjoyable side of the work, which they like doing”.

“I think the word around Flinders is that this is a great learning experience down here, and that’s one of the things that students say when they get back”.

“Because in rural settings the clinicians have always – being at the centre of … professional isolation, and we find that the students are actually influencing learning outcomes of the senior staff as well, because they’re being exposed to a lot more contemporary models of medicine than what we would … So, when they come here and say, look this is how we do this in Adelaide now, have you thought about this, it’s actually a two-way street for them, because as I said, unless you’re actually involved with your college and you’re involved in examinations, and you’re involved in peer review processes and all those sorts of things, you don’t get exposed a lot to what happens in major tertiary hospitals…”

(Interview, FU Partner 2, F)

“The centre piece of [the PRCC] is the apprentice model in general practice with one to one teaching there’s no question about it”.

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“…we've got very good GP supervisors, some of them are highly experienced now and they’ve involved themselves in medical education to the point in which they know a lot of the patterns which are so important to be able to bring to mind when faced with a student problem…”

(Interview, FU Clinician 1, F)

“Yes, so I'm pleased to be a mentor, I see myself as a mentor for medical students. I enjoy my involvement, I described myself yesterday to somebody actually, I was talking about what we do and I said I'm a very small cog in the grand wheel of things, but I think, or scheme of things I should say. But I think we do play a positive role with the students…”

(Interview, KL_REC004, M)

“They come for their observational days which is really they're there to watch they're not there they're not a hindrance by any means and in rounds they're just another couple of bodies on the round. There's really no detrimental impact for us. I guess the positive thing is if they are really interested then it brings out our you know it's always good to keep going over things with people to add teaching reinforce it to us and refresh our knowledge sometimes”.

(Interview, KL_REC001, M).

“…for me personally…I find it sometimes affirming as a GP to have a medical student and then sometimes you can see their visibly surprised [face] that you have a handle on things and that you know so much about a person or their background, and things that we just, we've done for a long time. And it's, so in a sense it's affirming for ones work”

(Interview KL_REC004, M)

**Discussion**

There seem to be at least five positive outcomes for the teachers of the rural medical programs from the quotations above interpreted in the wider framing of the interview and field note records. Interestingly, the positives, unlike the concerns and criticisms of teaching in the programs which are reported on later, share much in common. This may be because respondents feel the negative aspects more acutely and therefore are prepared to be more specific and differentiated in their commentary about them in order to ‘get them fixed’. On the other hand, it may be that a professional
commitment to medicine is something quite universal in nature and any pay-off engenders widely shared positive feelings about it.

Firstly, teaching in the program delivers individual rewards. Some of these are motivational in nature; others are more directly related to teaching as a vehicle for engaging with current research and literature. Put another way, a dollar delivers 2 outcomes simultaneously- students are taught and the teacher is taught.

Secondly, it seems to be that teaching in the medical programs is a form of performance accountability for the teacher. This in turn acts a stimulus to learn, to keep up to date, to not wanting to be seen by peers and students as someone who does not have their practice informed by the latest information and procedures.

Thirdly, teaching in the rural medicine programs seems to have benefits for practices. In some instances this occurs through students contributing to handling patient workload or bringing extra intellectual resources to a practice. In other instances, there is the community kudos which accrues through a practice being associated with doing a public good thing- training young doctors (hopefully) for rural communities.

Fourthly, for some who teach in the rural medicine programs it is the sense that they are making a contribution to the profession of medicine that forms the strongest bond with the programs. Put another way, they see themselves as passing on knowledge and skills to the next generation of medical practitioners. Associated with this is the societal impact of teaching in the rural medicine programs- helping to ensure that individuals and communities have access to one of the critical requirements for leading a full, productive and rewarding life- access to high quality medical services.

Finally, for some, the benefits of teaching in the rural medical programs accrue through the opportunity it affords for creating positive wash-back on the main-stream academic programs. Put differently, there seems to be a sense of being at the edge of something quite new and different, of being in a place and space which is not ‘the centre’ but is a ‘new centre’, a new locus of power for shaping and delivering medical education. The pioneering nature of the rural medical program and a feeling of needing to justify what is being done seems to bring a sense of excitement into the professional lives of some teachers.

As I argued in my research on how rural principals construct their roles, peripheral places can be locations of radical re-conceptualisation, can create new spaces for
thinking, different ways of seeing and interpreting, different ways of understanding and moving towards actions. This is essentially because the move to a location that is often interpreted as being less powerful rather than being positioned centrally, breaks conventions and, more significantly in terms of the development of Thirdspace, creates a ‘fertile context’ for ‘Othering’. Put another way, the “evocative process of choosing marginality reconceptualizes the problematic of subjection by deconstructing and disordering both margin and center…and new spaces of opportunity and action are created, the new spaces that difference makes” (Soja, 1996, p.98); extract from Halsey, R.J. 2007.

For development

There are aspects of both the Flinders and Monash rural medical programs which need to be addressed from the perspective of teachers and teaching. The following extensive quotations from the transcripts and field notes are illustrative of them:

“Q. Are there times when you feel the students are a burden?"

F: No. I think there are times when you know – I find the emergency department a difficult place to teach all the time because it can get really busy and then you kind of lose your student and I have done that a few times where I have been responsible for teaching someone through the day and they are following me around and I get completely distracted with something and I have forgotten to take them through it and involve them in what’s going on and you know, I think that’s a skill that I need to get better at and I think it’s something you just get better at doing – teaching; when you do it more often and it just becomes more natural, because I certainly know from my own history there were – there have been consultants that are comfortable teaching in any environment and I think it just reflects how you manage your own practice and I think when you are comfortable with what you’re doing you can teach at any point so no I wouldn’t say a burden, no but I have sort of forgotten they were there from time to time to be honest”.

“I am not sure how much research goes on here but certainly through universities and other hospitals there is more research going on. That stimulates a bit more”. 

(Interview KL_RE003, M)

“…it’s a bit hard to feel like we’re achieving something when year by year there’s not something to compare with because it’s always different to before, and but hopefully it will become bedded down now with this new structure here and the curriculum will
remain reasonably constant, so we'll have something to compare with year by year. But at the moment it's been, I guess an experience of change.”

“I'm just not certain whether again there's enough basic Sciences in terms of the Physiology, Biochemistry, Anatomy, Physiology, these sorts of things. I mean I'm not certain what everyone else does but I try and really put an emphasis on that... I'm a little concerned that we may end up with a lot of people who know a lot of facts and things but I'm not certain how they were derived by not having enough of the basic sciences…”

“I think I enjoy teaching ...not asking for money, but I think it should be recognised that we do a lot of teaching and no remuneration. Certainly our set time over here is paid at an hourly rate, but everything else I do is not paid, including in the rooms. And we are small business men, and when we're doing something which is not income generating, there are still people we employ in our rooms working, so that makes it difficult and makes it a consideration, the amount of time that we've got to give to teaching activities”.

“...do you think it could have any bearing on this whole business [of teaching in the rural program] if the University acknowledged us other than just [with] money, which is nice, but by sort of honorary, I don't know lectureships or something, I don't mean money to necessarily go with it, but rather the fact that basically we're mentoring but we're not actually, I don't know [being recognised]...Associate Professor is what we'd like”.

“Yes I agree with you. There is a special mechanism within Universities as you know, it's all formalised and all the rest, and one is you give a title like Associate Professor, another one is called, oh god I used to be one myself, where it's, you have academic status and all the rights of entitlements right, and it's a form of recognition by the governing council of the University, whatever body, that you are part and parcel of the University and you enjoy the rights and privileges for want of a better term and the association”.

(Interview KL_REC004, M)

“...the university must understand the ways in which it can recognise and value and reward clinicians now about once every 2 years there's a play about money but it's bigger than that and it's bigger than that in the context of the emerging primary health care ... because there are a lot of people who are covertly I think would like to see
primary health care initiatives advanced and not only because of the patient outcomes it might improve from that but also because they fear there's a chance to bring the doctors down to size and unfortunately we do see that from time to time so that's quite a potent amalgam when you think about it because the doctors are there beavering away they're time poor, they take on medical students, if you do a time and motion study they're not paid anywhere near what they deserve but they do it as a leap of faith as an act of faith and the reason that they do it is they hope that there will be competent people who can come back and look after their communities when they're not there, when they've moved on and that I'm sure is what propels them it's the Hippocratic oath at it's best”.

“…mandatory performance of research in order to be recognised both in terms of seniority and in terms of position is wrong I think that it's imposing another level on people who have other lives if you elect to join a university on the staff and that's also the different type but otherwise I think that tradition should be recognised for what they do and accorded the same opportunities for advancement”.

(Interview, FUclinician1, F).

“Q: Faculty development? That's training the trainers.
A: Yes, that's probably a bit inadequate. I think that some of the GP’s who are the trainers and we depend upon them very heavily now, particularly more so than ever and they could probably do with a bit more support. Now, I'm not quite sure how you do that because first of all they've got practices to run and those practices are very undermanned at the moment. But I think that they do need a bit more support in that area”.

“I think that the psychological support in the country is perhaps not as good as it in the city or perhaps it's not as readily available”.

(Interview, FUclinician2, F)

“$450, $500 a session or something like that, it's what you need, I mean, you're still not even close to covering your income, but at least, you're covering your overheads and at very least, and it just wouldn't feel like you've been used. So that's the really undercurrent, I mean I really feel, if I was to take, that's what's stopping me from doing it [training and development], it's this feeling that I'm expected to be a volunteer for the university... especially since every other training at a registrar level, at an intern level and so on, at least in general practice world, they are rewarded exactly like that, so why should it be different for this. And if you at least could cover your
running expenses and come away, and I think that the dollars, but running, actually taking a day out and doing a block stuff of training, is probably the best way of doing it...at least if you take the time out to do the training, then it's going to be protected and useful time, you can get a chunk done at a time, but it needs to, it would need to be … at a suitable level”.

*(Interview, FUclinician3,F)*

“It [having students]…makes my day less [e]fficient there's no question about that because in will typically use time between consultations if there is a few minute[s] between then checking some results, checking letters that my, I run a computerised practice so if the typing has been done I can flick over to the typing and check one or 2 letters, make an adjustment or 2 and then click on send because they go electronically as well whereas I feel less able to do so when there's a student there and feel more compelled to spend more time talking to them and I don't want to ignore them but it does have implications for me having students, it has some positive implications as well because you're more inclined to be justifying your thought processes and decisions and recommendations although I, if I do some self appraisal I probably do that anyway to an extent when talking to my patients…”

“…generally a 4*th* year student slows me down and there's simply not recognition for that I just, they ask to take them and I take them because I think it's important to do so but yeah just a little bit of recognition would be nice it would just be right, it's not I need the money I just think it would be right, be the right thing to do, if you’re taking the money for doing the training when actual fact I'm providing it for 6 weeks it doesn't seem quite right”.

“…the state government has got to start paying more respect to the specialist[s] who are in country and not regarding them as second rate to the ones that are in the city, they've got to look to us for some policy development instead of the city people, if I want a new ultrasound here I don't want it chosen by my woman’s and children’s hospital … which is exactly what happened they need to make it easy for registrars to come here not difficult…”

“…was very heavily involved with teaching the students, he’s gone; he’s gone because he's absolutely totally sick of the bureaucracy…which bureaucracy in particular?

…Country Health and the state government I mean we say things […until] we’re blue in the face and they don't really think we mean it until we walk away”.

*(Interview FUclinician4, F)*
“...one of the reasons I wanted to be involved in the review was really, just to sort of try and sort of get a better footing to the teaching of students who come here. We’ve had some discussions and we’ve had – I won’t use the word – we haven’t had a good relationship in some ways, and some of that’s been for a variety of issues. But we are interested to teach and we know that ophthalmology is something which is poorly taught at an undergraduate level, and that shows when people come out into clinical practice. So, we’ve had some concerns and, in a sense some of those concerns are still unmet, but I think it’s a case of it’s a work in progress”.

“I came to this country because of my rural background. I think the students get a very good experience. I think the biggest problem that they have is that there is a – and this was sort of something which was a concern at the beginning of the program – was that there is not enough super-structure, there are not enough consultants and so, in one sense one could argue at times that the level of teaching experience is at times ... there are gaps within it because, I mean just from experience, now ten days ago there were no positions in the hospital, and we’ve argued for a long time ... the local medical group that there should be more senior members, or more consultants ... available. And what’s tending to happen now, is we’re getting more and more students and doctors at a junior level and very little growth in terms of doctors at a senior level. So, that that does mean that there will be gaps also, we never really had at the beginning of the program a middle level of doctors in terms of registrars”.

“well it’s very hard to understand what that curriculum is and, in fact ... in the curriculum is poorly defined when there’s a very poorly defined undergrad curriculum in ophthalmology wherever you go, and so, most of the undergraduate curriculum consists of occasional lectures ... people ... sort of minor clinical exposure, and that’s a couple of short talks or workshop ... but basically, the exposure at an undergraduate level is very small... the deficiencies don’t really sort of, lend themselves well to PBL and various other things like that, because a lot of PBL is self directed, or can be self directed; you can take yourself on a particular pathway depending on the way things open up, but without appropriate bones, you can’t often find your direction. So, I think that there’s a very strong case at an undergraduate level for a series of didactic illustrated talks, and then you can move on to PBL later”.

“Now, the course obviously, will change over time and it will morph a little bit in terms of some of the illustrations might be ...but the basic principles and the basic structure has got to be the same because there has to be, I think some standardisation and we have to cover a certain amount of content to ensure that people have got the right bones to sort of deal with – I mean, that’s where something like the American Family Book works very well, because it goes through in a sort of structured formal way”.

(Interview FUclinicians5, F)
“[I] have some concerns about the definition of the curriculum- can only get to know people by getting to know people- a little more definition of the program (PRCC) may help with reducing some of anxiety… perhaps greater contact with GP supervisor would help”.

“Would be nice if you could get more students into local clinics- need more space and clinics are over booked…doctors and clinics give a lot- we need to give something back…the program is very dependent on GPs…if they opt out there will be no PRCC”.

(Author’s field notes, 29 April, 2010, F)

Discussion

There are at least 6 issues which respondents have identified through the interviews and focus groups that constrain being able deliver what it is they believe they need to deliver as teachers in the rural medical programs.

Firstly, the nature of the learning contexts. The specific example in the data above is an ED. There were other examples in the data such as lack of consulting space and distance between facilities and service centers. In relation to the data example, two comments may prove useful- the context itself is a rich learning vehicle and the value of it may be enhanced by preparation of students before they enter it which emphasises this. As well, some specific advice/training for teachers who teach in busy, problematic and somewhat unpredictable environments may be a useful thing to do to as well.

Secondly, research. There are two main dimensions to this. One focuses on an obligation that some staff feel they work under which is to become more engaged in doing research. This seems to be driven principally by university expectations re research is what academics do. There is a sense, not expressed by all teachers that because they do not engage in research and have not published their contribution is of a lesser kind. This tension/feeling needs to be managed productively because if the research drive is pushed too hard without any consideration as to how it may be incorporated into already very busy lives, then some staff could withdraw or scale back there commitment to the rural medicine program.

The other dimension of the research focuses on whether or not sufficient is occurring compared to other comparable university programs/settings. I do not have data to answer this from a quantitative perspective. However, I do think that both the Flinders
and Monash rural medicine programs are potentially very rich opportunities for catalysing research, and particularly research that foregrounds the significance of rural places and spaces in constructing and delivering high quality health services.

Thirdly are the related matters of keeping up with changes to what has to be taught and what is expected of teachers. Associated with these concerns is the pace and frequency of change and who is driving the change agenda. While there is only one quotation in the data set above which refers to teaching expectations bedding down and remaining consistent for some time, there were others interviewed who alluded to the frequency of change and time available to adapt to what they needed to do.

Fourthly, and related to point 3, there are the complex and contested issues of what should be taught, for what amount of time, and by whom. The issues go to the heart of curriculum design and delivery, about which more is said later. Although not widespread, there is some concern about students receiving sufficient grounding in ‘the basics’ for optimising successful study in specialisations like ophthalmology and psychiatry. I feel confident this is not confined to the rural medical program but it may feel to the respondents a very big issue because they teach and support students outside of the main academy. The sense of distance from the centre may be acting as a magnifier of concerns. Engaging with teachers who have these concerns and facilitating ways of addressing them would be wise, because as for research perceptions, the risk of letting discontent fester may result in staff withdrawing their services. As well, constantly presented concerns which are not addressed can over time, erode the energy of others and undermine bigger picture objectives.

Fifthly is the issue of remuneration and recognition of GP and specialist teachers in particular. The quotations in the data set from both Flinders and Monash are clear and consistent about these matters. There appears to be an out of pocket expense to being involved in the rural medical program. While most in one way or another saw this fact as being a form of contribution to the big objective of their involvement, it nevertheless also seems to be an issue that festers. Given that most—all?—who brought the matter of remuneration up are running a small business, it may be that offering to meet overhead costs for their involvement would be a very positive thing to do. Regularising their status with the university across the various sites and across both universities would also likely be a very positive move. Both Flinders and Monash have policies and procedures for making adjunct appointments. Although not represented in the quotations but related to the issue of the formal status of GP and specialist teachers, is the matter of academic status consistency across sites and programs as a whole. It is well known that differentiated treatment of staff which is not transparent can be a source of resentment and lead to staff minimising their work output and looking for other opportunities.
Finally is the matter of finding time for busy professionals to attend/be involved in training and development sessions. The respondents do not appear to be overly clear on what might be done to improve the current situation other than for 2 suggestions- fund them to attend training and their replacement costs and, do the training in large (day long) chunks of time.

**CURRICULUM**

**Framing comments**

Like many phenomena in education, curriculum is frequently contested and problematic while simultaneously enjoying high levels of consensus about how important it is ‘to have one’. Put another way, curriculum means different things to different people, and this is particularly the case when specialists are involved as contributors to a critical societal priority like the education and training of rural GPs. Bernstein (1971) has identified curriculum as one of three major message systems through which the regulatory purpose of education is achieved, the other two being pedagogy and evaluation. Curriculum, he argues, “defines what counts as valid knowledge” (p.47). The best description of the tensions inherent in designing a curriculum for a specific purpose that I have ever read is captured by the words of Raymond Williams “[a]n educational curriculum ..., expresses a compromise between an inherited selection of interests and the emphasis of new interests” (1961, p.150). This assertion encapsulates both the reproductive dimensions of education (continuation and traditions) and the reconstructive aspects (adaptation and change). Most importantly it underscores the contested nature of curriculum and the negotiation which inevitably occurs between interested parties to produce agreed statements of study.

Below are 20 quotations taken from the transcripts and field notes as evidence of 7 themes which appear to characterise thinking about and engagement with the Flinders and Monash rural medical programs in relation to curriculum. The themes are:

1. competition for finite time
2. study load
3. hierarchy of perspectives: hierarchy of knowledge
4. modes of delivery
5. where to direct energies and expertise- design or delivery?
6. foundation/core or elective?
7. navigating and negotiating

The themes are discussed following the quotations.

**Quotations/evidence**

“…I think the structured program we’re given to teach makes it quite easy from us as a teacher to teach it but perhaps doesn’t give quite as much flexibility. It’s supposed to be patient based and I try to get patient based but I’m always a little bit disappointed that we don’t spend much of my tutorials around the bedside, and I try to put that in a bit because I think that's a really good part of medical learning… I think it's, it seems to me, at least the equivalent of the teaching environment I had as a medical student, I think it's got a lot going for it”.

“I don’t like some of the things that happen, like we have this tute on a Monday morning at 8:00 o’clock and 2 or them, 2 of the 8 just didn’t front, and after a couple of weeks said “Oh well, they doing Gyny?” Because he says they're in the Gyny rotation at the time and they’d been told if they don’t turn up at the theatre at 8:00 o’clock then don’t turn up at all”.

“I found this year’s curriculum for students very, very busy and it seems like they’ve got very little chance to [respond to] “Gee why don’t you come on Tuesday morning, I might have an interesting clinic there”. They’ve got no time that they can sort of bargain with and change the time they come, whereas other years they’ve been able to come when my counsellor was there or when my Diabetes educator was there, or my Social Worker was there, or my Women’s Health Nurse was there, I’ve got all those things. So, they’re very busy and they’ve got no wiggle time to come to different clinics and that I see as an issue for them to just to have free time”.

“One thing I think we can hold our heads up fairly well locally, but I think we do engage with the students well and I think we try to make them part of the system, this is what I see anyway…I sometimes see the students involved in part of the system, it's not like when I was a student, whereas you got in the way and you were a bloody
nuisance…they’re welcome as part of the base hospital and I think that has to be a
benefit in your learning experience…”

“(Interview KL_REC004 M)

“…I mean I’m just not certain whether again there’s enough basic Sciences in terms
of the Physiology, Biochemistry, Anatomy, Physiology, these sorts of things. I mean
I’m not certain what everyone else does but I try and really put an emphasis on that”.

“[Monitoring and keeping students on track is] very important, like I keep a lot of their
log books, I know like middle year, I know exactly which, every one of those kids has
done, I have them all done, catheterisation, this, that, that, that, any case records,
MCR’s and I know how, what they’re up to. So I’ll push, I’ll say okay, I’ve taught you
this, you’ve had one practice, you need three practices – because it’s not just me
teaching them and then doing them once. So yeah ECG’s or whatever, you have to
really be right on top of them, because at the end of the year it’s just push, push,
push. They run out of time”.

“And one of the other difficulties is that each of the disciplines considers their
discipline to be the most important, and therefore, rather than the integrated
approach which N… is, they should only be spending their time in that discipline for
the time they give them, like 6 weeks at a time, and try to muscle in on the rest of the
time table a bit, so that is starting to settle”.

“(Are there things that could be improved?)…well the MTR’s definitely. But we’re
doing research in that to try and convince everyone else. Like the … case record, is
where we, assess their assessment skills, now when you go to a patient and do a
history, and do an examination, it’s a complete flow on, it’s a total thing, history,
examination, with an MRC you say okay you’re doing an examination, you’ve got 15
minutes. So you go out to this patient, do an examination, they’ve got clearly no
history, and it’s just…no communication with the patient beforehand to have that
rapport and…there’s just no flow on…a lot of things like that are driven out of
Clayton, so that's our Clayton curriculum that we have to [do]…

“Anything more on concerns or improvements…the long case scenarios where they
had a patient [they] followed…that worked really well.

(Interview KL_REC005 M)
“So we really need to recruit more specialists to be sharing the load for teaching, I think that's the main concern”.

“I think we have got a lot of specialists that do come to the area, well at the moment we do there's current political problems within the hospital at present but aside from that we do have a wide range of people that do visit here and maybe we should be taking advantage of that and making that a more formal part of their visit to Bairnsdale, maybe if they agree to be teaching the students that they wouldn't be paying facility fees or some sort of pros and cons”.

(Interview DJ_100412_003 M)

“Oh it’s good for our work, it’s good to keep you on your toes, like if someone’s asking you questions or wanting to understand things, then I have to make sure I know what I’m talking about so, that’s good for my work, because I have to go and check things out and make sure I know, and it’s a bit inspiring too to have young people around, I mean they’re intelligent, they’re interesting, they’re enthusiastic, so I think it just, yeah makes work a bit more interesting, and – my – yeah – I think most people feel the same way up there. Sometimes it adds more time to your work – because by the time you explain everything you’re doing, it actually makes jobs go a bit longer, but generally I think it’s probably beneficial – mutually beneficial that’s how I see it, I reckon it’s not just them learning it’s us learning too – because they’ve got all that new medical knowledge stuff that we’re probably out of date with – I don’t know”.

(Interview DJ_1000409_003 M)

“Just the learning opportunities, it’s huge…my 4 students are sick of hearing from me, but I say to them all the time in weeks in review when I see them on a Monday, “It’s there for you, it’s whether or not you’re prepared to take it on board and whether you’re prepared to access it. You can have it there, you’ve got great facilitators, you’ve got, there’s great resources in the library, you’ve got all of that information and things in the emergency department, do you want to go sit in there for 4 hours, you’ll learn so much, you’ll get so much, you’ll be able to take your log book in and get so much signed off, it’s whether or not you’re prepared to seek it out”.

(Interview DJ_1000409_005 M)

“…I guess from my point of view I get concerned that Metro, as in Clayton don’t understand how we work, like our programs different, and is almost like blinkers on when they set assessments and that because they don’t think of how rural schools
work. So, I guess I'm the agitator that's always on the phone saying “That doesn't fit into our program” or “Have you thought about the rural students?” or “No, our students can't come into that” and they don't, they're getting better and a lot of the faculty academics were not I think, initially were not so supportive of our program, of rural program. And so we were fighting against their attitudes that, like if you want to learn Paediatrics, well you won't learn Paediatrics unless you work in a big Paediatric ward. You know, so I think those attitudes are slowly being dwindled because like they're rolling out other programs and ours has been successful, like in the sixth year, it has been successful. So I guess, yes faculty concern me at times. Anything else, I think it worries me that we don't do enough tutor training, they're probably only small things. And I think we have to succession plan a lot, I think we have a lot of scope we can go to…"

(Interview DJ_100412_002 M)

…whatever direction they're coming from as students into the PRCC they're still confronted with an undifferentiated curriculum at the beginning of the year and that creates it's own set of tensions, that's the most difficult thing for them in the learning environment initially it's like touching a mountain with no … to scale it and part of the trick of course if for us to help them find the paths that suit their own learning styles so that they can ascend the mountain”.

(Interview FUclinician1 F)

“…I think [the law is] very poorly done at the moment. And in fact that's the new emphasis if you like, because the laws have changed recently as I pointed out, that the statutes are now different from what they used to be. And law is becoming increasingly important, with outlying things like, where it used to be not mandatory but now it is to notify alcoholism or drug addiction. Now that applies not only from the doctors concerns, to their partners, to their wives and family members which is yet to be seen how effective that is, but that's the law. That hasn’t been incorporated as far as I know into the course”.

(Interview FUclinician2 F)

…what's concerned me about the teaching program [referring to ophthalmology in particular] is that I guess we've been prepared to be available but, and, even times we've asked to be available but there's been a problem of a lack of inclusion and in a sense that we don’t know what – well it’s very hard to understand what that curriculum is and, in fact … in the curriculum is poorly defined when there’s a very poorly defined undergrad curriculum in ophthalmology wherever you go, and so, most of the undergraduate curriculum consists of occasional lectures … people …
sort of minor clinical exposure, and that’s a couple of short talks or workshop … but basically, the exposure at an undergraduate level is very small”.

“I know when we had access to the students, they appreciate the teaching. I think, at the moment the problem is because we’re asked to do, in two or three lectures, or two or three encounters what we think would take, probably twice or almost three times as long it’s very hard to give, even the simplest overview of what’s involved, or what’s required, or why things may or may not be important. And I guess the things we were talking about before, things like cataracts, glaucoma, macular degeneration and diabetes, they’re cold things, they’re just routine and that’s not talking about the red eye, the emergency problems, or dealing with chemical injuries, dealing with…I think there needs to be an attempt to sort of establish a curriculum, and then, at the same time integrate that curriculum into the teaching. Now, as I said, of necessity, I think most of the teaching initially, will be didactic, rather than PBL or, rather than any other sort of teaching methodology…I mean, when we taught the GPs we had nine hours, and we struggled to fit it into the time. I mean, there’s always going to be a sense of questions, and things which will distract. But certainly, three is not enough, you can really, only give them the scantest overview of common things, and then go into a situation where you might talk quickly about the red eye, and quickly about trauma”.

(Interview FUClinician5 F)

“The thing I would like to change most is the national medical registration [requirements] so we have more freedom to prepare generic clinicians…the shortage [of rural GPs] is being asked to be a solution to a problem- [the problem is being asked] to solve its own problem”

(Author’s field notes, 29 April, 2010 F)

“Fourth years in Adelaide have learnt very well how to be a fly on the wall- not so with the PRCC, students have an active role”…PRCC has provided a vehicle to achieve a better balance and dynamic between “the what [and] the how to be” a rural GP.

(Author’s field notes, 30 April, 2010 F)

Discussion

Taken either separately, in small groups or together, the themes which have emerged from considering the evaluation evidence in terms of curriculum and from my many years of involvement in designing, delivering and assessing it, are not surprising. The content is different to what I have encountered before and in some
ways, so are the contexts different, but the meta messages, positive, negative and neutral, bear striking resemblances to what can be found in other high stakes professional career preparation fields. In essence, the themes can be represented by a question: what learning must students engage with and demonstrate competence about, in order to graduate and commence practicing/working in the public domain?

Threaded throughout many of the quotations is the theme of competition for finite curriculum time and allied with this, the optimal way to use the time available once won, to maximise learning and outcomes. The competition for time and the pressure to use it to best effect are both Flinders and Monash issues though there are variations in how they play out. Time as a resource for learning is common to all in the project of educating rural doctors. Each participant—student, lecturer, administrator, hospital manager, community support—though having significantly different personal and professional demands on their time, all function within the parameters of a 24/7/365 cycle. In looking to improve the education of rural doctors, it may be fruitful to focus on time as a commencement point for discussions because it is a resource shared in common, than say curriculum content. While it is acknowledged that the quantum of time is a means to an end rather than an end in itself, its ‘commonness’ may prove a beneficial attribute when working through whether, for example, extra time ought to be allocated to studying ophthalmology in the PRCC Program.

One of the most complex challenges associated with ‘finding time’ in a crowded curriculum to do more or introduce new topics, is developing understandings amongst key stakeholders about the respective positions of each with a view to negotiating changes. Critical as well is negotiating and obtaining agreement that there is no white-anting of new decisions. Richard White’s (1999) concept of the middle ground, sourced from my 2010 Society for the Provision of Education in Rural Australia refereed keynote paper, may be instructive here.

White’s (1999) middle ground concept has its origins in his research and writing about the complex, dynamic relationships and rivalries between the Native American Indians of the Great Lakes region and the French, British and Americans from the middle of the seventeenth century until the 1812 war. While it is true that the will of the Native Americans was eventually overcome, the middle ground process in the lead up to this eventuality remains instructive. The heart of the middle ground is a willingness of parties to recognise that there are spaces, physically and socially constructed, that are beyond and other than the ‘home bases’ of each, and which are productive for progressing their own agendas. In White’s words, the middle ground is “a process that arose from the willingness of those who…[sought] to justify their own actions in terms of what they perceived to be their partner’s cultural premises” (White, 2010, p.1). Further, “[a]ny congruence [between parties], no matter how
tenuous, can be put to work and can take on a life of its own if it is accepted by both sides” (White, 2010, p.1). Through the process of working together, the exploration and discussion of what White calls misunderstandings, “new meanings and through them new practice—the shared meanings and practices of the middle ground [emerge]” (Lear, 2006, p.30).

While White’s middle ground is a product of “a quite particular historical space” (2010, p.1) it may be instructive for exploring what is required to optimise the competition for finite curriculum time and the preparation of rural doctors. The middle ground focuses on creating physical spaces and socially constructed spaces: contexts for exploring ideas which Soja would assert do not pressure for premature closure and that foster “continuously expand[ing] the production of knowledge beyond what is presently known” or possible, if constrained by current policies and practices (1996, p.61).

Closely related to the pressure on time to do all that is determined to be valuable towards the preparation of a rural GP, is the very real issue of the design of the curriculum and the study load it generates for students. It seems that both the curriculum of the Flinders and Monash programs, while thought of very highly by most students vis a vis hands-on and theory co-joined to create real-relative learning, can also be overwhelming in terms of managing competing study priorities. While calculating a ‘full study load’ is necessarily subjective, it is possible to place some parameters around it, even ones which are fuzzy and somewhat flexible. Put another way, it may prove beneficial for students in both the Flinders and Monash programs to build into the formal allocation of curriculum, time for self reflection and renewal, notwithstanding pressure to allocate more time for particular areas of specialisation.

Thirdly, the evidence selected relating to curriculum is indicative of a hierarchy of knowledge and also a hierarchy of perspectives about the knowledge required to prepare a person to be a rural GP. A hierarchical approach to curriculum frequently generates resentment among advocates of knowledge lower down the pecking order and also drives those who are the custodians of high status knowledge to do all they can to maintain its ranking. This is a winners and losers view of curriculum or as has become popular in public debates about which university/university program is better than another, league tables. In responding to some of the concerns that can be grouped around hierarchy, it may prove useful to think of the knowledges central to educating a rural GP as a set of 4 concentric circles rather than a ladder. My preference would be to identify the 4 circles as primary, secondary, tertiary and other knowledge. Other is not a remainder table or a catch all for anything which does not fit into the other 3 areas- rather it is intended to emphasise knowledge which is important for a rural doctor to have but is fundamentally not accumulated over time in a systematic way. The clearest example that comes from the data is the concern
expressed about there being insufficient time for studying the legal dimensions of being a GP in terms of mandatory notification.

Fourthly, designing and developing the curriculum versus teaching appears to create a dilemma for some staff involved in the rural medical programs. Put succinctly, they do not have sufficient time, and in some instances, perceived sufficient expertise, to be involved in both the construction of the curriculum and teaching it. A compounding factor in the curriculum constructor-curriculum teacher choice is the fact that many of the teachers, as well as being GPs and specialists, operate small businesses so one eye always has to be focussed on covering costs and maintaining viability. Teachers who are hospital or agency based, while not having to maintain a small business, do have to ensure their salaried position obligations are met. There is a clear sense however, that for GPs, specialists and agency teachers, being closely associated with curriculum that is innovative and leading edge, does bring an additional sense of challenge, excitement and reward to their working lives. The ‘bigger picture’ significant point here is the multi-dimensional value of having a high status, high stakes university program embedded in rural and regional communities.

Fifthly, there is the very important issue of students predominantly, but also staff, navigating and negotiating the curriculum. Associated with this is the matter of curriculum specificity and rigidity compared with curriculum flexibility. Like other aspects of curriculum already referred to, striking a productive balance between these is complex. Having made this point, referring back to comments made by students, being able to pursue interests and tailor your study program is a highly valued feature of both the Flinders and Monash rural medical programs. As well, one of the hallmarks of a profession is that members not only possess a specialist body of knowledge and skills; they are also involved in continuously creating and negotiating their role in order to best meet the needs of their patients/clients. With this in mind, being immersed in a learning environment imbued with negotiating and negotiating is likely to be of more benefit than not. A critical requirement is however, to ensure that all who learn and work in such contexts are clear about the parameters within which negotiation and navigation has to occur.

Finally and related to the earlier point on hierarchy of knowledge, there is a tension between central influences and power and regional influences and power in terms of shaping curriculum and associated assessments. This appears to be more accentuated in relation to the Monash program than the Flinders. It is not dysfunctional but it does seem to be something that requires ongoing and very thoughtful consideration. An important but obvious point to make is that both central and regional perspectives working together will be more productive than either trying to gain dominance or the exclusion of the other. From the perspective of enhancing curriculum to prepare rural doctors for successful practice, it may be helpful to step
outside of familiar contexts and reflect upon what bell hooks (her chosen naming) says about the potential of margins to influence and reform centers. The extract is from my doctoral thesis:

In her work, hooks among other things, choses margins, marginalisation and marginality as opportunities and spaces for “radical openness” (Soja, 1996, p.12). For hooks, intentionally moving out of the centre to the peripheral zones is a “critical turning point in the construction of other forms of counter-hegemonic and subaltern identity and more embracing communities of resistance” (Soja, 1996, p.97). The nature and the power of the place of marginality is, in essence, transformed through the act of choosing rather than having it imposed according to hooks (Soja, 1996, pp.98 & 99). Moving toward peripheral places as locations of radical re-conceptualisation, hooks asserts, can create new spaces for thinking, different ways of seeing and interpreting, different ways of understanding and moving towards actions. This is essentially because the move to a location that is often interpreted as being less powerful rather than being positioned centrally, breaks conventions and, more significantly in terms of the development of Thirdspace, creates a ‘fertile context’ for ‘Othering’. Put another way, the “evocative process of choosing marginality reconceptualizes the problematic of subjection by deconstructing and disordering both margin and center…and new spaces of opportunity and action are created, the new spaces that difference makes” (Soja, 1996, p.98).

COMMUNITY

Framing comments

Definitions of community, like curriculum, are varied, often quite contested and also imbued with a degree of ambiguity. Wheatley and Kellner-Rogers (1998) while writing mainly about ‘community’ at a global level, make two important points about community which are helpful in framing this section on my evaluation report.

Firstly, there is the productive tension between the desire to be free as an individual while at the same time, searching for relationships to nurture individualism. Wheatley and Kellner- Rogers describe this as “the absolute need for individual freedom and the unequivocal need for relationships” (1998, p.10).

Secondly, while there seems to be an ever increasing focus on competition and on becoming a ‘self made person’, there is another ‘reality’ far different to this. Indeed the reality may become more pronounced as boundaries of all kinds shrink, driven by population growth, the rise and rise of communications technology, increasing mobility and so forth. In Wheatley and Kellner-Rogers words, “[l]ife is systems-seeking; it needs to be in relationship, connected to others” (p.11). Further, “[s]taying centred on what the common work is, rather than on single identities, transforms the
tensions of belonging and individuality” into energy and resilience for community (1998, p.15). Put another way, the bigger picture, the wider context, is informative and transformative in terms of purpose and sustaining community.

Community placements and community engagements as integral components of both the Flinders and Monash rural medical programs are vehicles for exploring and nurturing the formation of professionals as individuals, and professionals who have a strong sense of place and purpose together with a service focus for others.

Following are a series of quotations from the transcripts and my field notes pertaining to community. From them, there appear to be 5 themes that form the basis of discussion about Community in light of the evaluation. The 5 themes are:

1. valuing of rural medical students
2. students as vehicles for staff engagement with community
3. problematics and opportunities for partners and children
4. community as a curriculum resource
5. selection of students and community

Quotations

“…have you got any sense of how the community feels about the students and to what extent the students are involved in the community?... I think they’re very accepting here what I have found of patients. They’re very happy to be involved with the students. They’re very happy to let the students examine them”.

(Interview KL_REC003 M)

“… he [the Director] ensures they sort of get the feel of the community because he actually physically takes them along and organises community functions for them to go to. A few of them [also] get involved in sport while they are here in sporting teams”.

(Interview KL_REC001 M)
… I don’t give them any choice; I take them off to Rotary as well because I’m in the Rotary club. And they come along and they sit there and they smile and they’re talking to people next to them, but the Rotary clubs just delighted, they feel like they are contributing to this student’s development. Again, it’s small town stuff, but there’s a real buzz, the community loves to feel that they are contributing to the education for that student and thereby they’re hoping, and they all ask ‘Oh are you going to come back?’… they do and the student who will say ‘Well I might’.

“The partner, the spouse and the children, if the spouse isn’t welcome that’s an issue, and secondly the education of course, as you know with children. But, you know that can be built upon, that’s not always a negative, and Mildura’s very lucky compared to small towns like Sea Lake…”

“…to what extent do you think the community engages with the students and to what extent does the students engage with the community, from your perspective? It depends on the student. Most of the students that are up here for the whole year, so our third year students, if they’re a sporty type person will become involved in sporting clubs, whether it be, we’ve had hockey, soccer, tennis… a lot of them also work in the community…they get jobs while they’re up here”.

“I know from being in the doctor’s clinics, and having the students on the other side of the desk, before I came here, the students came into the doctor’s clinics, probably 99.9% of the patients were quite happy to have a student in there, with the aim, oh yes, hopefully they’ll come back and be doctors… So the public buy into, or the community buys into…? Yeah absolutely, because they want doctors back here, so they’re quite happy. We have the media coverage also”.

(Interview KL_REC005 M)
“They always get a big welcome when they come here, usually a big dinner the community comes out, they get their photo in the paper in the local paper, the communities quite aware of it”.

“And they get involved I mean a lot of them play sport and a few years ago we best and fairest at the netball was one of my medical students… we have a few sporting expertise students that really get very keenly involved in local community and I think that’s also helpful for their acceptance in the practice”.

“Some get involved in tutoring as well they tutor high school students… [and some were] involved at the special school last year to work with the teenage boys”.

“Certainly in our smaller community, the ones that have got on well with the community are the sporting people; the ones that have no sporting interest tend to get dismissed”.

(InterviewDJ_100412_003 M)

“Within the fourth year program there [are] certain areas of the curriculum that you can bring the community into, especially into the GP curriculum, where we do disabilities and that, and it’s been a part of our curriculum that I think we’ve always looked at trying to improve… we worked with one of the special schools last year and a project [has] developed out of that”.

(Interview DJ_100412_002 M)

“[Is the] community aware of the students and to what extent are they involved? No, I think that’s probably one of the big issues, is that we’ve been too busy in all these years of getting the program to work and I think it works very well. But I think one of the things that perhaps we missed at the start was, is marketing ourselves. I think Gippsland Medical School have been very clever at marketing themselves and if you ask people in the community about the medical school here, not a lot of people seem to know about it, but they know about Gippsland Medical School at Churchill. In saying that… if I ask anyone in the community to be involved in, you know like Community Health Centres or any of the community psyche clinics, certainly they want to be involved”.

“It’s very important and I think that, for example here I think the Lions Club has adopted the students and that’s very good, they get a lot out of it. And in fact I know
that the students from last year I think, they’re involved with the Lions Club and they’re friend’s, and it’s a major issue in staying in a country area, and they’ve benefitted tremendously from that... I think this was the only town where a service club actually picked them up... I think Berri is now on board. We went and made some presentations to Berri Lions and Berri Rotary. I think the issue there was they didn’t really understand what their role would be and what it would be about, and once they found out about it, they said yeah okay”.

(Interview FUClinician2 F)

“I’m not at the moment an advocate of part time rural training, because I think the ideal thing for this PRCC is to be immersed in the community, to live in the community and to be doing what the GP is doing full time. To come and visit part time, and go back to another community, I think that probably has risks attached to it, so, not being a GP, I’m just saying that from the outside, so I think that's one thing you have to be careful of, and again, just having you select the appropriate sort of trainees that are going A) get on well in a rural setting and B) get on well with their other trainees living close together, I think that's important, and I think there have been some issues with that, but I’ll leave that up to the clever people to decide how you select them, but I think selection is important and the ones that obviously have the good attributes, they excel when they're here, the ones that don’t have those attributes seem to struggle, that's the only thing I could say”.

(Interview FUClinician3 F)

“I just don’t think it works when you have a situation where we might have four students coming in and sort of say alright, well we’ll get four community members, you, you, you and you, and you’ll get to meet, and that’s fine, you take that person and I’ll take this person, and that’s all done, because you’ve highlighted this synergy that must, absolutely must be developed, otherwise you just meet the person and say well that’s fine, thank you very much, call me if you’ve got a problem, and that's the end of it”.

“I think also, it’s really important for the university that the actual program is – that people out there know why the students are here as well, because – well where I come from, in the region I come from in the Mallee, we are not blessed with many GPs and therefore, it’s good to encourage the students to … have a mindset that, maybe it will be good to come back into a rural area, and this is just the entrée – that to come back later for the main course because that would be a really good idea”.
“…I think … from a community point of view that we need… [to know what a student is interested in]– well it’s a CV in a way… find out where there might be keys in that interest, like horse riding, like endurance running, like whatever; we need to know that from a community point of view, so that when those contacts are made, if you’re in a group and you know that you can help with horse riding or something, and you’re the person that’s interested in it, as a student, then you’re going to gravitate … But if it’s other things, let us know and we’ll find it. Because I think most of the community members have pretty well integrated into their communities, and I think that students should know that there’s no lack of contact available…”

“… the student communication network is extensive, and if a student has what they perceive to be a bad experience in one practice that filters down and it can have all kinds of [consequences]”

“(Interview, FU Community 1)

Discussion

Community valuing of rural medical students occurs and also acts as a vehicle for staff engagement with community. They are common to both the Flinders and Monash program.

Firstly, medical students are valued as individuals; although some might read this as a trite comment, the fact is, they are very pleasant young people to have around. Given the fairly heavy negative load of information about young people that comes through the popular media outlets, this is worth noting and indeed celebrating. In terms of what is happening nationally both here and overseas with the exodus of youth from rural areas, having young (mostly) medical students intentionally moved out into rural communities sends a positive signal to them.

Secondly, medical students bring with them a raft of interests and expertise which rural communities’ value and it can be argued, need. These include the ability and willingness to play sport, to attend and participate in service clubs, and take part in cultural events. In addition, some students work in the community part time and,
interestingly, no evidence of medical students displacing local young people from jobs was presented to the evaluation panel. Some medical students engaged with the community through schools, either in terms of tutoring individual students or presentations on specific topics. Medical students from both Flinders and Monash are a rich instance of an injection of social capital into rural and regional communities which one can deduce from the comments of ‘locals’, is like a breath of fresh air—often their experience is one of high end social capital leaving their communities.

Thirdly, students act like a form of bridge between the existing range of services and what community hope will be available in the future. This is evident in the willingness of local members to be patients of/for medical students, to invite them into their homes and to arrange community based social events for them. The presence of students and the informal conversations which happen between students and locals about what students will do in the future, nurtures the bridging function of student rural placements. It seems to realistically, and at times optimistically, raise hope about ‘there will be doctors in our town in the future because of what we are doing with and for students’. As one person put it very succinctly, “the community buys into [the Rural GP program] because they want doctors back here…” (KL_REC005 M).

Fourthly, and referred to earlier, it is clear that the qualified doctors who teach and support rural medical students and especially those located in rural and regional centres, really value interacting with them. Not only do medical students bring expertise to help with workload, they also bring expertise which contributes to the professional development of rural practitioners. As well, having medical students placed in rural communities has had a seminal impact on how the curriculum for rural medicine students is conceptualised, delivered and assessed; “it has transformed how we think about clinical education”

(Author’s field notes, PRCC. 28/4/10).

Placing medical students in a rural or regional community is not all smooth sailing. Some complexities and pressure points can arise when a student also has a partner and/or children. Employment for a partner can be an issue; schooling for children has been sited as an issue as well. Issues like these go to the heart of selection processes and signal the complexity of matching placements which have to incorporate numerous personal variables as well as the professional learning ones embedded in the rural clinical model. In relation to selection for the Flinders PRCC program, one contributor to the evaluation suggested that selections for successful placements may be improved by involving a couple more local people in the process.
Finally, it is clear from the data that actions are taken to keep the community informed about the rural medical programs and what student are doing. To broaden the base of people who have a reasonable working knowledge of the rural medical programs and from this, might be more confident than at present to formally and informally advocate for the programs, there seems to be potential for holding community forums or similar to ‘engage with students and staff and spread the word’.

**ADMINISTRATION and SUPPORT**

It is abundantly clear that both the Flinders and the Monash rural medicine programs are very well served by their administrative staff and the services provided by them. All of the engagements I had during the evaluation with administrative staff reinforced that they saw their mission as doing everything they could to make a rural medical student’s time in a rural community as productive and rewarding as possible.

Students were especially fulsome in their praise of the work done by administration staff to make their study and their stay as beneficial and enjoyable as possible. Writing as someone who has worked in education over many years and in many different roles, the amount of administration support and the diversity of it for both programs, is significantly more than would normally be provided for an equivalent number of pre-service teaching students and professional staff. This observation is made without reference to financial and FTE data and does not take into account the uniqueness of the preparation required to ‘graduate’ a competent GP compared to a competent teacher.

**LEADERSHIP**

Leadership is a critical component of any successful enterprise. In both the Flinders and Monash rural medical programs, I encountered many instances of highly committed and highly effective leaders and leadership. There was not time to focus in depth on the matter of leadership; nevertheless as for the administrative staff support for the programs and students in particular, it is abundantly clear that the leaders involved continuously strive to do all they can to make students’ experiences as rewarding as possible. I gained a strong sense that the leaders are ‘on the job 24/7’ when it comes to searching out and fine tuning ways and means of ensuring that the rural medical programs stay at the forefront of innovative medical education. The leaders are very well informed about the politics of medicine in rural communities as well as the professional issues. They are appropriately opportunistic and build complex, enabling coalitions of interest and expertise to progress objectives. The formal leaders of the programs are highly respected by their colleagues, staff and students. Several of these also expressed concern about leaders’ workload and
burn-out, some of which is generated through having to travel, regularly advocating for program resources, and maintaining practice as a GP or specialist.

To the best of my knowledge, most of the formal leaders of the rural medical programs are what might be described as the pioneers of the innovation. It would be very useful for both Flinders and Monash to plan for leadership succession if the programs are to grow and become a ‘normalised’ way of preparing GPs for rural practice. As well, there is also the issue of how the leaders, and also the teachers, of the programs are formally recognised in terms of academic status and tenure. This was not something I pursued in depth. However, sufficient comment was made by various respondents to the evaluation to indicate it is an issue that needs to be addressed in a transparent and fair way. It appears that Monash has more work to do here than Flinders.

Finally, there is one other aspect of leadership which appears to be very significant in terms of the success and impact of rural medical programs- support and facilitation from senior executives within state departments of health. The evidence to hand applies only to the Flinders PRCC though there may be instances relevant to the Monash programs which I am unaware of. The ‘ground floor’ discussions between Flinders and SA Health about establishing a rural medicine program have clearly played a seminal role in the journey and achievements of the PRCC. Leadership on both sides was crucial- there were senior people involved from the start- “you have to have people negotiating who can impact [and to make things happen you] need [and had] champions who can instill a culture that is not added on, one that makes things happen”

(Author’s Field Notes, April 29, 2010)

ADDRESSING RURAL HEALTH WORKFORCE SHORTAGES

It was agreed that one of the key questions for the comparative evaluation of the Flinders and Monash rural medical programs would be, how does the program address the rural health workforce shortages?

Answering the question can be approached in at least 2 ways.

The numbers way

The first is essentially statistical. It focuses on the number of program graduates who move to rural areas to practice, at what cost per unit, at what percentage of the full
cohort of a particular intake and so forth. In political terms, are rural medical programs addressing the shortage of rural doctors?

There was evidence presented for the evaluation to support this interpretation, this ‘numbers game’ aspect of the question. Having declared this, there was also some equivocation about making judgments of success when contributors were pressed for details or asked to reflect on, is the effort really producing rural doctors? I am inclined to the view that the equivocation was more representative of people wanting to be accurate and fair about the programs rather than having doubts about impact. What this may also indicate is the need for some user friendly statistically based information which could be widely disseminated and readily understood to ensure staff and community supporters are clear about what is being achieved and at what cost.

Another aspect of the ‘numbers game’ aspect of the question relates to the impact of the programs on individual student choices. That the programs do have an impact on students has been clearly established in earlier sections of this report, and particularly the first section which deals with students and their learning, However, there were also instances where students declared that being involved in a rural program was seminal in changing their view about living and working in a rural community; for others it was confirming of a preference or a decision to practice in a rural area.

Evidence included:

“Q. Do you think the rural clinical schools programme; contribute to attracting and retaining doctors in rural areas?

A; yes.

Q2: How do you know that?

A: Because I know students that have been with us that are now practicing out in rural areas. Not very many, but some. No actually there is, there's quite a few, there's a lot up in Darwin at the moment, 3 I know are, like registrars in country hospitals, not here, but in other Victorian regional hospitals-

Q: How many could you actually count in your head, if we said 10?

A: 10-
Q: [How many] could [you] name, if you were on a witness stand here, [a] royal commission?

A: Probably name like 8 maybe.”

*(Interview record KL_REC005 M)*

“We have 3 South East people likely to return and stay”

*(Author’s field notes, April, 2010, F)*

“Is the program successful in recruiting people? Yes but I believe there are a lot more barriers to retention. So, people may, be being exposed become interested, but I really think the major determinant of retaining people in the country is independent of those. I mean it’s basically, their backgrounds, their age and the experience that comes further down. I mean, people come back to the country because they want to come back to the country”.

*(Interview record, FUClinician5 F)*

“I would definitely consider coming back to practice, definitely. I’m fairly close to finishing. I will need to go back to the city to finish off rotations that I can’t do here but certainly as a specialist I would consider working more peripherally. I think and I suppose I would never have considered if I hadn’t have had this 12-15 month stint and really enjoyed it but also your lifestyle as a doctor is much better.

*(Interview record, KL_REC003 M)*

**The capacity building way**

The second way of considering the question is in terms of what having rural medical programs located in rural and regional communities contributes to these communities, the medical and other professionals who work there, and the main
Evidence included:

“The PRCC has brought a credibility to Rural GPs - the respect of rural generalists and specialists has risen… the educational development around the program has had a great impact on curriculum… when students first went off-site it had a positive wash-back on the curriculum”.

(Author’s field notes, April 2010, F)

“Well certainly for the Nursing staff there’s been a lot more collaborative learning. But the Nursing staff use the students not only for supporting their education but being more proactive in education because “Gee I’ve got to teach a medical student now” like, make sure that I know what I’m doing. The hospital actually, some of the staff believe that the students should be involved with quality in the hospital, like involved with policy and procedure of the hospital as well. The staff, what else? Many, many things the hospital staff feel, but they look at this as, some staff look at this as their program, like they should be more involved with the program or ownership, have more ownership over the students. ”.

“The benefits, I think there’s been lot’s and lot’s of benefits. I think, like for the community, for us to be here, like there’s the local, one thing it’s employment for the community, you know like there’s all this community engagement …, there’s employment for the community, there’s … for the hospital, there’s recruitment for the hospital. There’s the patients, our students are used to educate patients here, the patients give back, like they’re allowing the students to see them, so there’s all those, there’s many relationships that go on. There’s relationships and benefits to the staff in the hospital, to the supervisors who gain, like more interaction, from my research a lot of the supervisors say, like the students are fun, it makes your day, that you’ve got someone, sort of really enthusiastic to learn, it makes me go and learn. It came through with the nurses, it’s great to have them here, it’s boring otherwise, and they form their relationships there. That’s certainly good for the hospital, whether they see that or not to have the Uni here. Like it certainly, economically it’s good for the town as well, good for the tutors economically we, certainly for the tutors they’re, we trying to build up more education for outside, just the acute care and, like trying to provide education to the GP, that’s another avenue that we need just a few more in. Instead of GP’s having to go to Melbourne, that they need … from here, so we’re trying to, whether bring in programs like the Rest program from that, I know they’re happening here in June, … all those sorts of programmes need to come here so GP’s don’t have to go out. So that’s something that we’re pursuing”.
“Whilst I think that beyond rural GP’s even if we get specialists who one maybe prepared to come back to the country but if they’re in the ivory tower in the City at least appreciate the difficulties that the rural GP’s have and we’ll get a far more sympathetic hearing or far more supportive attitude from, hopefully that will filter through the City specialties”.

“I have no doubt that the students, and I talk from experience here, of seeing them under exam conditions, that the students that have been out in PRCC are much more able to establish a rapport with their patient and in an exam environment, that matters and it stands out. Overall they have a much more ready rapport with the patients. And I think they’re more experienced, certainly they get more experience at the procedural things, catheter’s, intravenous lines, better sections and things like that, they get a lot more experience with that”.

PRCC helps expose students to living in a rural community,] to understanding and experiencing the closeness and relationships... to experience the impact of weather on our communities and businesses..."
The PRCC is a vehicle for learning “the what [as well] the how— it contextualises learning… definite benefit is introducing students to see the benefits of being here—can’t see these on a short rotation”

(Author’s field notes, May, 2010, F)

“I think you know, it’s good to give them – if they’re not from a rural area themselves, they get a taste of what it might be like to work somewhere peripherally and I think particularly up here – all the people I have heard really enjoy it and it’s a place a lot of people will consider coming back to once they have qualified at least for a period of time. It’s beneficial from that point of view. You know, I suppose they have got – there’s a sense with having a clinical school here it makes them less isolated that they have got a clinical school right on base and they’re not isolated from their clinical school back in the big smoke”.

The capacity building impacts of both the Flinders and the Monash rural medical programs are very significant and, from the perspective of pushing against the deficit framing that is frequently associated with rural and regional contexts, is really the real good news story.

More than ever before, vibrant productive rural communities are critical to our sustainability and indeed, the sustainability of the world. This may seem like a very big call but it is not when put in the context of population growth and the ever increasing pressures being placed on the natural environment. For interested readers on this topic, the following is an extract from my SPERA 2010 paper referred to earlier:

That rural communities are critically important to the future of Australia should by now be beyond question. I have argued elsewhere there are five major issues confronting Australia which underscore why it is essential to maintain a very strong focus on the sustainability of rural communities (Halsey, 2009). Briefly, food security is critical and as Pretty (2002) argues this is really not a choice item—“[w]ithout food, we are clearly nothing. It is not a lifestyle or add-on fashion statement. The choices we make about food affect both us, intrinsically, and nature, extrinsically. In effect, we eat the view and consume the landscape. Nature is amended and reshaped through our connections—both for good and bad” (p.11). Second is the issue of energy—much of what Australia consumes daily is sourced from rural areas—and the pressure to move from fossil based sources of energy to green renewable sources continues to grow. Third is the issue of water and water management. Cullen (2005) argues that “[w]ater is the key to living and to economic development in Australia” and that a “sustainable future [for Australia] will entail extensive collaboration between governments and stakeholders [like education] to ensure that the true costs of water
use are borne equitably and accountably in both rural and urban areas” (p.79). Fourth is the profoundly important matter of arresting the decline of the natural environment, which includes climate change, and developing new paradigms of valuing it so that it, in turn, can do what it has always done—sustain life in all its complexity and diversity. “...an intimate connection to nature is both a basic right and a basic necessity...we have shaped nature, and it has shaped us, and we are an emergent property of this relationship. We cannot simply act as if we are separate. If we do so, we simply recreate the wasteland inside of ourselves” (Pretty, 2002, pp.10–11). Finally there is the issue of managing Australia’s territorial security in a context of escalating population growth and likely impacts of climate change. My intention in making this point is not to hark back to the days of ‘populate or perish’. Rather it is to draw attention to the fact that the combined consequences of world population growth and population displacement due to climate change (and other events) may result in millions of people having to find somewhere new to live or, in a comparatively short timeframe, become water based citizens of the 21st century because their land has been claimed by the sea.

In addition to the issues as briefly outlined above, there are other facts and consequences of human interactions with nature that accentuate the importance of the sustainability of rural communities being a major national priority. During the working life of the Baby-boomer generation, the world’s population has nearly doubled. This growth has been matched, and in some ways driven, by wave after wave of new discoveries and the rapid adoption of technology of myriad kinds. Paralleling this growth has been an increasing use of natural resources, many of which are non-renewable like fossil fuel and minerals. Just one piece of data provides a lens into understanding the enormity of human impact on non-renewable resources: “concrete consumption in cities each year is equivalent to 730 Great Pyramids of Giza...[or] eight times more than the total global automobile fleet” (Brugmann, 2009, p.12).The growth in consumption of non-renewables has come at an enormous cost to the natural environment, and has driven some of the systems we rely on for sustainability perilously close to the point of being unable to recover. Further, ‘being unable to recover’ presumes we have accurate ways of measuring pre-intervention inventories of nature’s ‘treasures’. While there may be some contention with this in academic and research circles, many people who live close with nature and the natural environment—who have essentially enjoined with nature in a dance of sustainable production and harvesting—can speak from deep and long experience that ‘things are not as they once were’ when it comes to nature’s capacity for self-renewing and self regulating its ‘taken for granted’ abundance.

Another way to visualise the point I am trying to make here: think of the decline that has occurred to major fisheries and fish stocks around much of the world and, while doing so, also ask yourself is there not something deeply ironic about farming fish when nature can ‘supply’ fish so more effectively if given ‘half a chance’. Kurlansky’s profoundly insightful and disturbing book on the biography of the cod and its demise overtime—“abundance turned to scarcity through determined short sightedness” (1997, rear dust jacket)—ought to be compulsory reading for anyone who wants to understand how human intervention can bring renewable resources to the brink of extinction. As Diamond argues,
“[m]anaging environmental [natural and renewable] resources sustainably has always been difficult...because of ubiquitous problems...the resources initially seem inexhaustibly abundant; that signs of their incipient depletion become masked by normal fluctuations in resource levels between years or decades; that it’s difficult to get people to agree on exercising restraint in harvesting a shared resource (the so-called tragedy of the commons...); and the complexity of ecosystems often makes the consequences of some human-caused perturbation virtually impossible to predict even for a professional ecologist” (2005.pp.9 & 10).

As well, consider what is continuing to happen in many rural areas and communities both in Australia and many other parts of the world, as globalisation and its relentless ‘addiction’ to economy of scale ideology and ‘natural’ ways of operating, continues to transform rural landscapes, sucking out people and replacing them with technology and mass market franchised services and bigger tractors, wider seeders, more efficient extraction machinery, faster turn around times and the demise of local stores, producers and purveyors of daily staples and services. As Brugmann (2009) asserts, “[s]cale permits the splitting of fixed costs and known risks over a large enough group of users to make an activity attractive or service profitable in a big way... [and together with] density that increases the sheer efficiency by which we can pursue an economic opportunity...[which in turn] increases the range of opportunities and level of ambition that can be viably pursued...” (p.27). Though not the a main focus of this paper, it is important to recognise that one of the really complex challenges of rural sustainability is developing economic models that are less reliant on economies of scale to deliver efficiencies and viability.

Renewable resources and the spaces and places which nurture and regenerate them have generally been treated as though they are infinite when even a brief examination of a photograph of Earth taken from outer-space reveals a planet that is finite, though imbued with systems and natural laws that have an apparent inexhaustible capacity for regeneration—for sustainability. Add to this a world population by 2050 of between 9 and 10 billion and Australia’s population growth from 22-plus million to around 35 million in the same time, and a complex mix of issues, challenges and factors clustering around sustaining rural communities becomes ever more urgent.

The rural medical programs are like a breath of fresh air to those who know and believe that drawing every aspect of education and training for every critical human service into cities is not ‘the only way to go’. They are also a breath of fresh air to those who can see that economy of scale thinking and modelling is not the be all and end all of economics. What an economy of scale world view does in terms of imposing metro-centric thinking on rural communities is devalue human scale and also largely turns a blind eye to the many costs which those who live and work in small communities meet in order for them to survive, and sometimes prosper.
A quotation from the 2009 Elford lecture I delivered seems an appropriate way to conclude and emphasise why, notwithstanding further developments and fine tuning and taking a long term and responsible view of the future, it makes eminent good sense to maintain and enhance the Flinders and Monash rural medical programs:

*Rural* Australia has to move out of the rain-shadow and become centred in our national debates, national policy making, national valuing, and national psyche. *Rural* Australia has to move out of the rain shadow because all Australians will be beneficiaries when this happens. Given the challenges Australia and Australians face looking to the future, some features of which I have sketched out, in ‘bottom line terms’, it makes little—actually no—sense to not harness the full capacities of our rural contexts and communities. To make the point another way, consider what would happen to Australia if rural Australia shut down overnight and all who lived there moved into the cities. We know this will not happen but allowing yourself to play with the thought for a few minutes is a sobering thing to do.

High quality education, at all ages and stages of life, that is accessible, affordable, available, adaptable, acceptable and accountable, and that is led imaginatively, is a key to moving rural Australia out of the rain-shadow. From the Bradley Review of Higher Education in Australia (Department of Education, Employment and Workplace Relations, 2008) target of 40% of 25–34 year olds having a first degree by 2020, to high quality locally available training that is internationally recognised, to every young child having access to quality child care and pre-school, *education is the core capita of and for the future.*

Actualising this reality in rural and reducing the complex web of problematics frequently associated with this requires what Veronica Brady calls “a renewal of the imagination, a transformation of the way we see the world” (Tacey, 1995, p.1). Or, extrapolating from Lear’s (2006) treatise on the pain and the possibilities of the transition of the Crow Native American Nation, we need to rediscover—restore—a fertile middle ground context for change and progress, a place where “…diverse peoples [and thoughts, aspirations and ‘day to day pragmatics’] adjust their differences through what amounts to a process of creative, and often expedient misunderstandings…[and] from these misunderstandings arise new meanings and through them, new practices…” (p.30)

Meadows, Meadows & Randers (1992, p.209) in Black (2005, p.24) “define a sustainable society as ‘one that can persist over generations, one that is far-seeing enough, flexible enough and wise enough not to undermine its physical or its social systems of support’ ”. A sustainable society is also one that embraces all of its places and spaces; all of its human resources. A sustainable Australia will be one that fully embraces rural and moves it out of the rain shadow and into the mainstream of national policy, national practice, national life!
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